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ABSTRACT

The Choctaw Tribe is the first and only tribe to develop a health delivery system to take over an existing Indian Health Service inpatient facility. The takeover was accomplished in January 1984 under the Indian Self-Determination Act through a contract with the Indian Health Service. The Choctaw Health Delivery System includes a 35-bed general medical facility, dental facilities, a community mental health center, a supplemental nutrition program, a hemodialysis treatment program, and satellite clinics in three outlying communities. The report provides an historical overview of the takeover process, including brief sections on the three planning stages. The developmental and operational phase section has 24 sub-sections covering such matters as the kinds of methods used to determine what programs would be offered, how the tribal personnel system was affected, and aspects of the 2-year Health Education/Risk Demonstration Project (including implementation of the School Health Curriculum in grades 5-6 at Bureau of Indian Affairs schools). A section on the future of the system examines the potential of a nursing home project and providing health services to non-Indians. The summary and recommendations section lists positive results of the completed take-over and shares experiences learned from the process. A bibliography, a list of abbreviations, and five exhibits close the report. (BRR)

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DEVELOPMENT OF THE CHOCTAW HEALTH DELIVERY SYSTEM

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Mississippi Band of Choctaw Indians

RC015226

"My earliest recollections of the Mississippi Choctaws are of the many things they needed. Now you've established schools, tribal offices, tribal enterprises, and now the medical facility. Health is the basic foundation for all human potential. A man may be poor, a man may be uneducated, but if he has health he still has a chance."

— Dr. Emery Johnson, Director, Indian Health Service, at the dedication of the Choctaw Health Center, April, 1976.

At ground-breaking ceremonies for the Choctaw Health Center in November, 1974, Congressman G.V. Montgomery, Chairman Phillip Martin and Dr. Emery Johnson discuss construction.

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MISSISSIPPI BAND OF CHOCTAW INDIANS
OFFICE OF THE TRIBAL CHIEF

TRIBAL OFFICE BUILDING
ROUTE 7, BOX 21
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TELEPHONE (601) 656-5251

Mr. James C. Meredith
IHS-USET
1101 Kermit Drive
Oak Towers
Nashville, TN 37217-2181

Dear Mr. Meredith:

This documentation of the development of the Choctaw Health Delivery System was prepared in accordance with contractual agreement between the Mississippi Band of Choctaw Indians and the Nashville Program Office, Indian Health Service.

In the document you will find a historical overview, an analysis of planning efforts, a description and critical analysis of developmental and operational activities, future plan for the Choctaw Health Delivery System, and recommendations. It is important to note two major aspects in this developmental project:

1) Contracting of an established IHS facility with inpatient facilities under provisions of Public Law 93-638

2) Development of new services and/or facilities through savings from IHS contracted programs and/or utilization of resources outside the IHS system

We wish to thank all those who are involved and/or cooperated in the development of the Choctaw Health Delivery System, particularly the Tribal Council, the Health Committee, the Choctaw Health Department staff, the Choctaw Service Unit staff, and the Nashville program office. Gratitude is extended to Binh Nguyen who compiled information and prepared this document; Skip Bridge, Lynn Crews, and Bill Fitzgerald who reviewed the manuscript and made editorial suggestions.

We believe that the Choctaw experience in the development of its Health Delivery System will be helpful to those who would like to follow the same or similar paths. We would like to express our appreciation for your continuing support of our health program. Please feel free to share this document with other tribes or tribal organizations.

Sincerely,

Phillip Martin

Phillip Martin
Chief

PM: bmw

DEVELOPMENT OF THE CHOCTAW HEALTH DELIVERY SYSTEM

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DEVELOPMENT OF THE CHOCTAW HEALTH DELIVERY SYSTEM (THROUGH PL.93-638 CONTRACTING OF AN EXISTING IHS-PHS SERVICE UNIT WITH INPATIENT FACILITIES)

INTRODUCTION

The past several years have shown a marked increase of contracts between the Indian Health Service (IHS) and Indian tribes or Indian organizations. Many of these contracts were written under authority of Public Law 93-638. Under 638 contracts, many tribes have developed and are successfully operating their health delivery systems. The majority of these health delivery systems are involved in public health, prevention activities and offering primary care services on a outpatient basis; inpatient services are usually provided through contractual arrangements with local hospitals and providers under the Contract Health Service Program (CHS) better known as the Contract Medical Care Program (CMC). In areas such as California and the United South and Eastern Tribes (USET), which are comprised of many newly recognized tribes, the Indian Health Service is no longer going onto the reservation to construct a federal facility and to set up a new Service Unit. It appears that, in locations where no previous IHS operations exist, the current disposition of the Indian Health Service is to provide health services to the Indian population through contracts with the tribe, tribal organizations or outside agencies. It might be assumed that the Indian Health Service is committed to the philosophy of Indian Self-Determination; and it has found out that a tribally managed health delivery system is an effective and efficient way to provide health services to the Indian population.

On the contrary, contracting of health services on Indian reservations with established IHS Service Units has been limited primarily to non-direct patient care activities and non-traditional IHS-operated programs such as: Community Health Representatives Program, Mental Health/ Alcoholism Program, Prevention, Public Health programs, and Ambulance Service, etc. Few tribes are taking over the management of an inpatient or primary care facility.

In the USET area, with the exception of the Cherokee tribe that has a dual tribal-federal health delivery system[1], all other tribes and tribal organizations operate their health delivery system through contract. Only three tribes, the Mississippi Band of Choctaw Indians in Mississippi, the Miccosukee and the Seminole Tribes of Florida, took over a program that was formerly operated by the Indian Health Service. The Choctaw Tribe, however, is the first and the only tribe to develop a health delivery system to take over an existing Indian Health Service inpatient facility.

The Choctaw total takeover was accomplished in January 1984. It was a perfect example of a planned, gradually phased-in takeover of an existing IHS Service Unit. This major undertaking was achieved through the efforts of the tribal Chief and the Tribal Council Health Committee though active involvement in policy-making and progressive planning. It took almost a decade to plan, recruit and train appropriate personnel, overcome bureaucratic and budgetary obstacles, and to defuse local opposition, through communication and demonstrative implementation. To no surprise, opposition to the tribal contracting effort came from federal employees who were concerned about the absolute security of employment they enjoyed under IHS management. The most vocal opponents were Choctaw employees of the Indian Health Service at the local facility.

In general, the Indian Health Service and especially its Nashville Program Office (formerly the USET Program Office), is regarded by many as supportive of the philosophy of Public Law 93-638. Unfortunately, in many instances, appropriate contracting mechanisms were not in place and the applicable IHS rules and regulations put the tribal organization in jeopardy politically, financially and programmatically. It is the tribe's opinion that tribal expertise in planning and

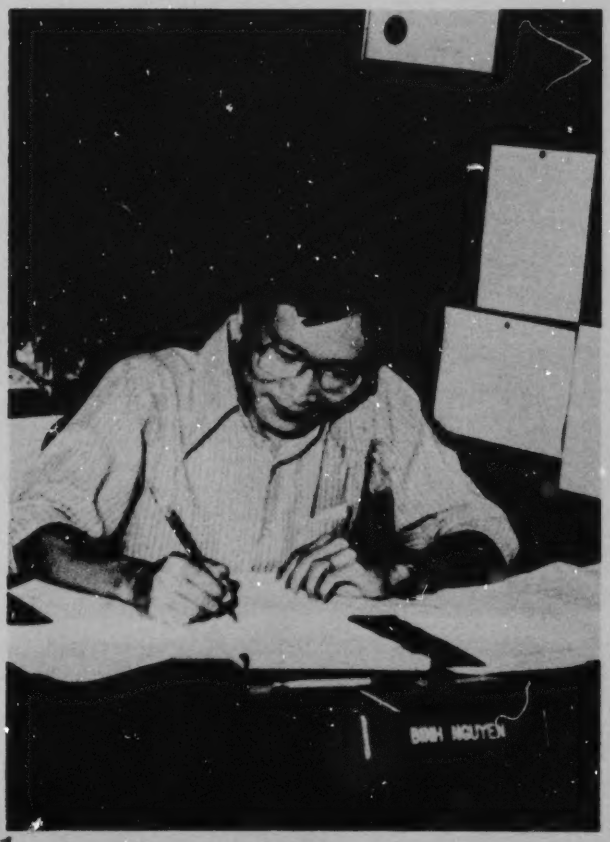
[1] On the Cherokee, North Carolina, reservation, the Indian Health Service primarily operates the Hospital, while the tribe, through its Tribal Health Department, has a Buy-Indian Contract to provide outreach, public health, and home health services as well as support services to the hospital.

management played a vital role in this contracting project. Without a team effort of various professional disciplines within the tribal administration such as administrator, planner, lawyer, and accountant, the contracting of the Choctaw Hospital would not have been achieved. During the Choctaw contracting process, many obstacles were removed and many rules, regulations, policies and procedures were refined. The Choctaw project drew special attention from Dr. Emery Johnson, former Director of the Indian Health Service and an ardent advocate of tribal Self-Determination. In addition, Dr. Everett Rhoades, Director of the Indian Health Service, took special interest in the development of the Choctaw tribal health department. During his first month in office he visited the Choctaw reservation on a fact-finding trip.

One important aspect of this contracting process is to learn and to fully understand the IHS system, the IHS budget, and its budgetary process. Tribal officials have worked closely with IHS staff, outside agencies, and other tribes in this endeavor. On many occasions, the tribe had tested and challenged IHS rules and regulations. In 1982, the tribe filed a declination appeal seeking a workable interpretation of the costs of contracting issue. Tribal delegation walked out of two contract negotiation sessions with IHS officials and refused to sign a contract in which funds for direct health services were reduced to support indirect costs. At one point, it appeared that a contract would not be signed on time to continue the operation of the already contracted programs, the IHS notified the tribe that it was ready to execute the retrocession/reassumption process. Fortunately, the retrocession and reassumption never came true and the appeal was never carried out. The matter was resolved without the actual hearings.

Another important aspect of contracting is to work with congressional representatives to create changes. Many rules, regulations, and issues beyond the control of the Indian Health Service have been changed through congressional mandate. Details of the Choctaw contracting effort will be elaborated in the later sections of this document.

From left to right, Chief Phillip Martin, Dr. Joseph Exendine, IHS Chief of Community Development and James Meredith, Nashville Program Office Director at the contract signing ceremonies in the Tribal Council Hall, January 3, 1984



Binh Nguyen, Director, Choctaw Health Department (1978-1983) and Health Planner (1984)

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Maxine Dixon, Chairperson, Tribal Council Health Committee, discusses patient care with hospital staff

Office building of the Tribal Council Committee System

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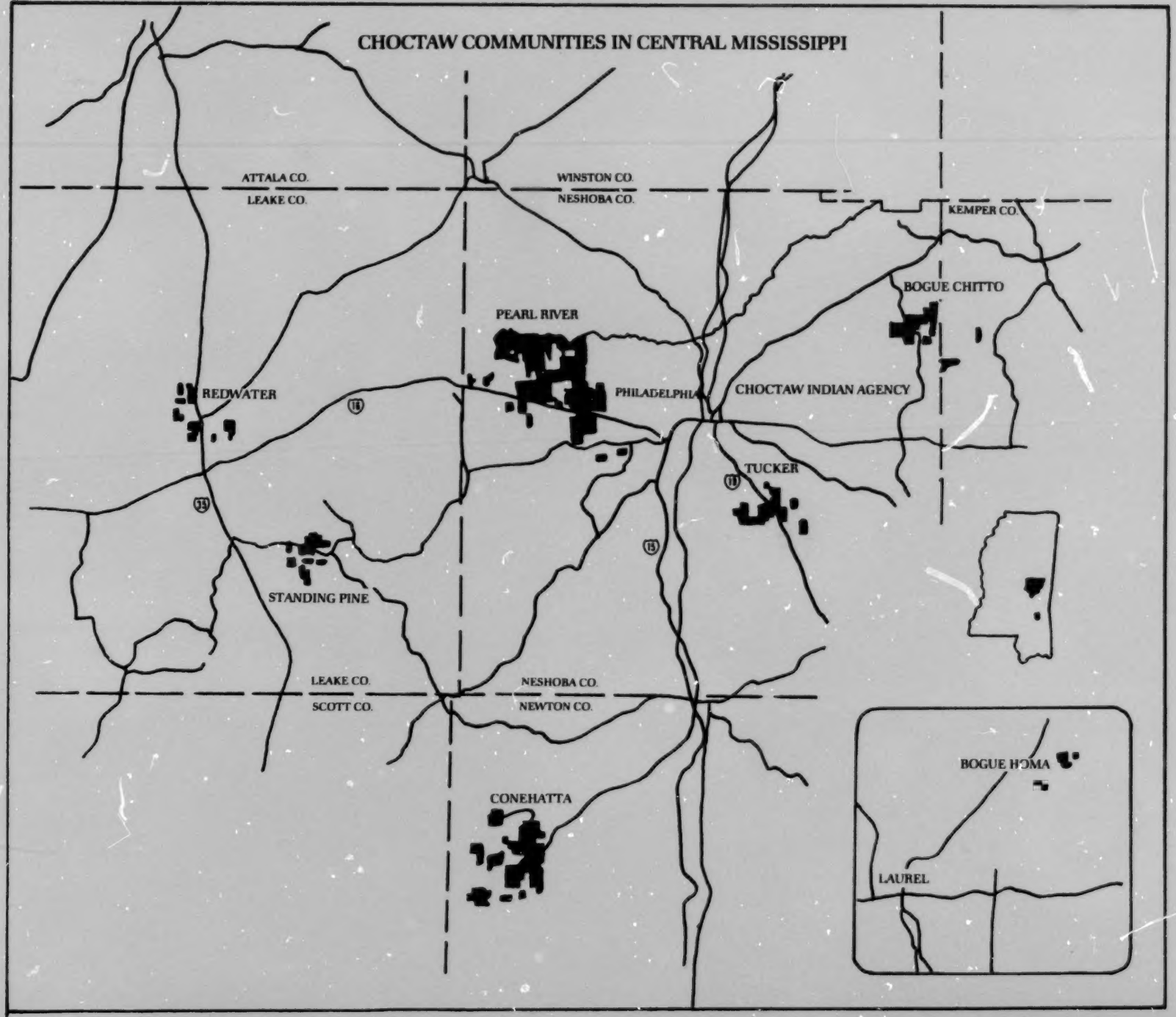

CHOCTAW COMMUNITIES IN CENTRAL MISSISSIPPI
ATTALA CO.
LEAKE CO.
WINSTON CO.
NESHOBA CO.
KEMPER CO.
BOGUE CHITTO
PEARL RIVER
REDWATER
PHILADELPHIA
CHOCTAW INDIAN AGENCY
TUCKER
STANDING PINE
LEAKE CO.
SCOTT CO.
NESHOBA CO.
NEWTON CO.
CONEHATTA
BOGUE HOMA
LAUREL

Neshoba Democrat, Philadelphia, Miss., January 11, 1984

The Neshoba Democrat

Tribe Assumes Management Of Choctaw Health Center

The Mississippi Band of Choctaw Indians has taken over all management of the Choctaw Health Center in the Pearl River Community.

The takeover was under the Indian Self-Determination Act through a contract with the Indian Health Service.

The contract was signed during ceremonies at the Tribal Council hall on the Choctaw reservation by tribal Chief Phillip Martin and representatives of the Indian Health Service, including Dr. Joseph Exendine, Indian Health Service's chief of community development; Micheal Tiger, executive officer of Indian Health Service's Nashville Program Office, and James Meridith, Nashville Program Office director.

Management of a comprehensive health delivery system is not new to the Mississippi Band of Choctaw Indians. Over the past eight years the Choctaw Health Department has managed all public health programs throughout the reservation and operated the Choctaw Health Center jointly with the Indian Health Service.

Under the new contract, the Indian Health Service will cease to have direct involvement in the day to day management of the health delivery system.

In his remarks, Chief Martin credited Binh Nguyen, Choctaw Health Department director from 1978 through 1983, with being instrumental in this contracting effort.

The Choctaw Health Center was opened in 1976, to replace an aging facilty constructed in 1926 in Philadelphia. Chief Martin was instrumental in acquiring a congressional appropriation for the new facility.

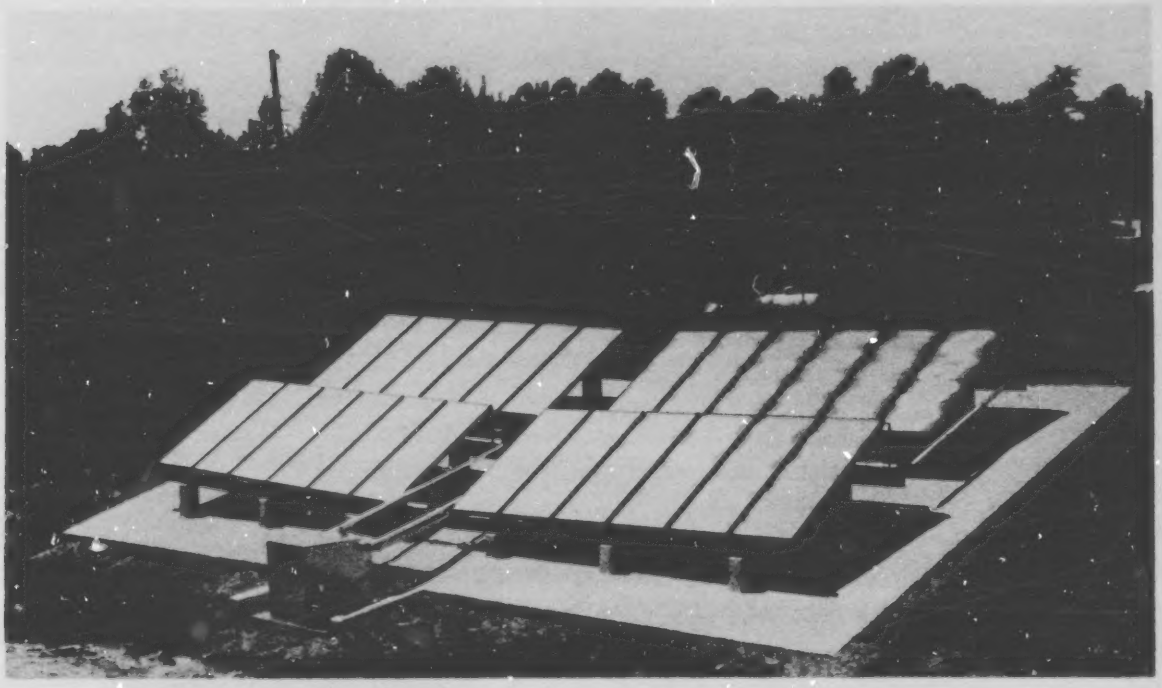
A 35-bed general medical facility which provides both inpatient and outpatient services, the Health Center also includes dental facilities, a community mental health center and a WIC supplemental nutrition program.

It is the headquarters of all Public Health activities including satellite clinics in three of the outlying community (Bogue Chitto, Conehatta and Red Water). The Center provides hemodialysis treatments through a cooperative arrangement with Kidney Care, Inc., of Jackson.

The total takeover was achieved with the active involvement of the five-member Tribal Council Health Committee, chaired by Maxine Dixon, a Council member from the Red Water community who has been involved in the project since its inception.

During the negotiating process, Martin consistantly stressed the quality of care to be provided and the responsiveness of the tribally-operated health delivery system to the health needs of the Choctaw people.

The Choctaw Health Center, the new inpatient facility constructed in 1975 in the Pearl River community.



The solar system designed and installed in 1983 to provide hot water to the Choctaw Health Center

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The old Indian Hospital in Philadelphia, Mississippi constructed in 1926

Redwater Clinic in Leake County.

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Reception desk and waiting area at the Bogue Chitto clinic

Lucille Von Seggern, RN, Family Nurse Practitioner with her patients at the Bogue Chitto clinic

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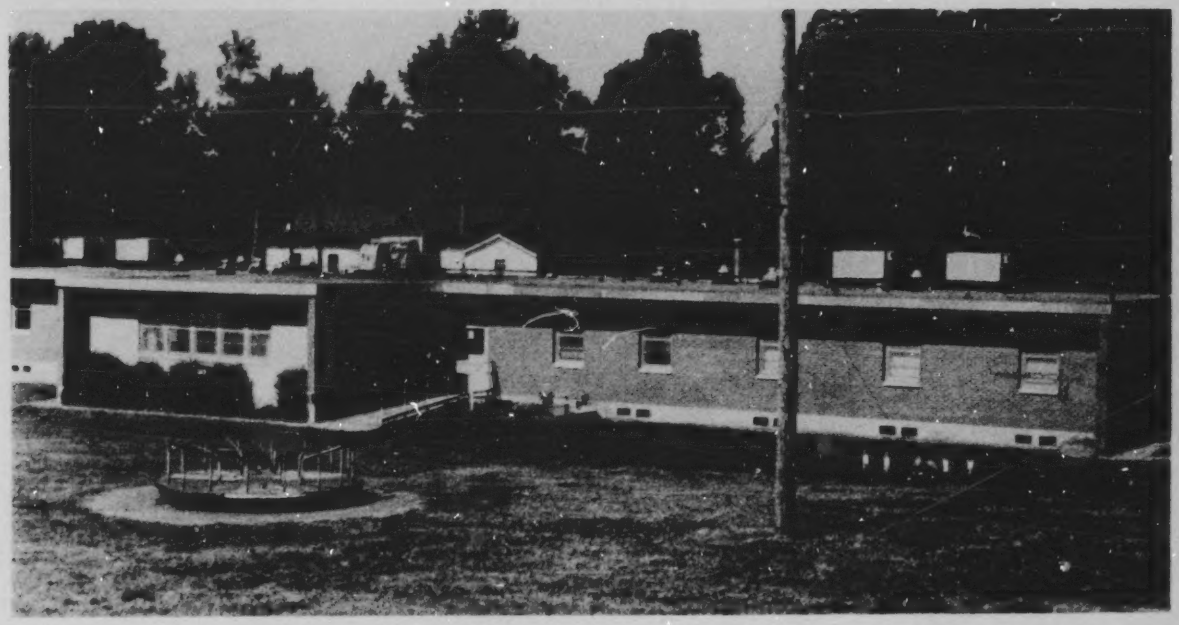

Conehatta clinic

A patient receiving hemodialysis treatments at the newly established Kidney Care facility (1983)

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HISTORICAL OVERVIEW

Following the recognition of the Mississippi Band of Choctaw Indians by the United States as an Indian tribe pursuant to the provisions of the Wheeler-Howard Act of 1934, the tribe adopted a Constitution providing for the periodic election of a Choctaw Tribal Council based on proportional representation from the seven recognized Choctaw communities. In 1963, the Tribal Council established its first Business Office to begin to manage a small fraction of its own affairs and to gain experience in planning and managing its own programs.

The first Choctaw Hospital was constructed in Philadelphia, Mississippi in 1926, and was initially operated by the Bureau of Indian Affairs. This facility was transferred to the Division of Indian Health (DIH) of the U.S. Department of Health, Education, and Welfare (DHEW) in 1955. The Division was the initial organization of the Indian Health Service.

As early as November 26, 1963, the Tribal Chairman, Phillip Martin[2], wrote to the Secretary of Health, Education, and Welfare, after the Tribal Council was informed that the hospital construction for the Mississippi Band of Choctaw Indians was "removed from the budget." The letter recommended that the Public Health Service re-evaluate the program in order to better meet the needs of the Indian people it served.

Immediately after his letter had been sent, Chairman Martin convened the Tribal Council in emergency session. On December 11, 1963, the Council passed resolutions CHO 8-63 and CHO 9-63. The first resolution acknowledged the Philadelphia Indian Hospital as vital to the tribe's existence and the second strongly supported the planned modernization or replacement of the hospital.

On April 14, 1964, resolutions CHO 19-64 and CHO 20-64 were adopted by the Council. These are summarized as:

(1) The Choctaw Tribal Council endorsed the construction of a new hospital and continued control of the health facilities by the Public Health Service[3].

(2) The Tribal Chairman was given authority "to work with DIH on development of plans for the new plant, its location and plans for the overall development of the health needs of the Choctaw people."

Resolution CHO 5-65 is a request by the Tribal Council, through BIA channels, for the BIA and the PHS to construct the new hospital on the reservation, at the Pearl River community, the central location of tribal operations. Although the IHS was supportive of the tribal requests, it was unable to secure funding for the construction of the new facility. Only with the active involvement of the tribe and its leaders through congressional testimonies in 1971, 72, 73 did the new facility become a reality. In 1974, after tribal efforts, chiefly with Rep. Julia Butler Hanson, Chairperson of the House Appropriations Subcommittee on Interior, and supported by the Mississippi Congressional delegation, had resulted in an add-on appropriation of $4.5 million, the Indian Health Service started the construction of a new facility in the Pearl River community to replace the old facility in Philadelphia. All health services for the Choctaws have been provided

[2] PHILLIP MARTIN started to work with the tribe in 1957 as a council member from the Tucker community. He was Director of the Choctaw Community Action Agency for five years and served as Tribal Chairman for 12 years. Martin has been Chief since 1979. Without his strong advocacy for self-determination and self-sufficiency, this 638 contracting effort would not have been achieved. Martin has brought the Mississippi Band of Choctaw Indians from invisibility and powerlessness to national respect and admiration. He believes in the effectiveness of speaking directly to government leaders in Washington, D.C., of testifying before Congress, and of dealing directly with the business and financial communities.

[3] At that time, there were fears that health services for the Choctaws might be contracted out to local hospitals. In the 1965 Evaluation Report on the Choctaw (Mississippi) Reservation, officials of the Division of Indian Health, PHS, US-DHEW noted "any attempt to move toward a contract-type of operation for any services will be ardently opposed by the tribal group." During these early days, "contract" meant to contract with a local hospital, an outside provider, not with the Indian tribe.

for or coordinated from this new facility, the Choctaw Health Center since its opening in 1976.

Prior to 1966 and the funding of the Choctaw Community Action Agency (CAA) under the U.S. Office of Economic Opportunity, the tribe had little voice in government services and did not operate any programs itself. Experience in self-government through CAA programs led to a broad program of tribal self-determination through political action, program development, and contracting to provide services through the tribal government.

The Choctaw Self-Determination philosophy was adopted by the tribe in July, 1971. Its aims, goals, and efforts are in accord with President Nixon's 1970 Indian Policy Statement on Indian Self-Determination. The philosophy of Choctaw Self-Determination can be summed up as follows:

(1) The long-run goals of all tribal efforts are to end Indian poverty and to substitute tribal control for federal management of Indian reservation.

(2) Lasting change on an Indian reservation must come from action by the Indian people.

(3) Fundamental change can be initiated by tribal leaders by bringing the major decision-making processes under tribal control and generating a sustained and coordinated tribal development effort.

(4) These efforts can only be accomplished by a strong tribal government which can retain the active support of its people.

The tribal leaders also recognized that the existing tribal government structure (which was virtually without system or organization) would have to be transformed into a stable and effective management system which could in the long run absorb the BIA Choctaw Agency and the IHS Choctaw Service Unit.

Tribal leaders recognized that such a transformation would require:

1. The development, adoption, and implementation of standardized management and organizational procedures to govern all tribal operations and employees.

2. A substantial rearrangement of roles, powers, responsibilities, functions, and processes within the existing government structure.

Consequently, on August 16, 1971, the Tribal Council authorized the Tribal Chairman to engage Peat, Marwick, Mitchell and Company, a nationally known consulting firm, to conduct a comprehensive analysis of the entire tribal government structure.

The report of the Peat, Marwick, Mitchell and Company's analysis and its recommendations were submitted to the Tribal Council. The Tribe accepted most of the recommendations and initiated a comprehensive reorganization of tribal organization structure. The Tribal Council adopted resolution CHO 18-72, a resolution to establish goals and objectives of the Tribal Council for the period 1971-1973. One of the most important articles in this resolution was:

"Article XVI: This Tribal Council shall seek to position itself to administer and operate on a contractual basis, all federal programs that are now conducted by other agencies for the benefit of the tribe. Such a policy will enable the Choctaw Tribe to gain effective control of key socio-political institutions which affect the Choctaw people."

This resolution provided the initial direction for planning and reorganization. The reorganization plan submitted by the Tribal Chairman to the Tribal Council was adopted January 12, 1972, through Resolution CHO 61-72. At that time, the tribe already operated several health related programs through grants and contracts:

1. Community Health Representatives (8 outreach workers).
2. Alcohol Education (3 para-professionals, NIAAA).
3. Mental Health (2 para-professionals and 1 professional).
4. Health Education (1 professional and 4 trainees).
5. Primary Care (3 National Health Service Corps assignees).

Subsequently, all these programs were consolidated under the Choctaw Department of Community Health Services (August, 1972). One of the primary missions of the newly-established Department of Community Health Services was to prepare preliminary plans for full tribal contracting of all USPHS functions and facilities on the reservation; it was projected at this time that all health services on the reservation would be placed under tribal control by 1976.

In "Accelerated Progress through Self-Determination," an annual report of the Choctaw Self-Determination Project, it was noted:

> "During FY72, a Mississippi Choctaw[4] was appointed as Director of the Choctaw Service Unit, IHS. This landmark appointment should contribute to a more rapid and orderly absorption of Choctaw Service Unit functions by the Choctaw tribal government."

While the Tribal Council saw the need to better organize, it was also mandated to do so. In December, 1974, members of the tribe adopted by referendum a Revised Constitution and Bylaws. The new Constitution separates the tribal government into executive and legislative branches. This revised document outlined new roles and responsibilities for the sixteen members of the Tribal Council and defined a manner of relating to the Chief, who would be the principal tribal administrator and head of the Council. The office of the Chairman of the Tribal Council was changed to that of tribal Chief. The Chairman had been appointed by Council every two years. The Chief is now elected at large by a majority vote of tribal members to a four year term.

The new Constitution also extended the term of Council members from two to four years, with half of Council up for re-election every two years. This staggered system creates stability within tribal government.

In early 1975, the Tribe moved a step further toward total contracting of the IHS Choctaw Service Unit by acquiring a health management team, made up of one tribal employee and two managers with IHS experience[5]. Phillip Martin left the Tribal Chairman office in June 1975, and

[4] The first Mississippi Choctaw Indian appointed Service Unit Director at the Choctaw Service Unit was Calvin J. Isaac. He resigned from this position the same year to return to the school system and was replaced by another Mississippi Choctaw, Frank Henry. As a result of the Revised Constitution and Bylaws, Isaac became the first tribal Chief elected by popular vote for a four-year term, from 1975 to 1979. He is currently Principal of the Choctaw Central High School within the BIA system.

[5] JAMES M. COX, RS, MPH was Director of the Choctaw Health Department from 1975 through 1977. A Sanitarian by training and a Commissioned Officer with the U.S. Public Health Service, Cox had extensive management experience with the IHS as one of its top managers. He was on detail to the tribe under the provisions of PL.93-638 and was instrumental in equiping and staffing the new facility in Pearl River. Under Cox's leadership, the CHC received its first two-year accreditation by JCAH.

WILLIAM A. BETTS, DrPH, an internationally known researcher, is also a Commissioned Officer of the USPHS. Betts was the Director, Community Health Services, Choctaw Health Department during the same period, 1975-1977. Before accepting the Choctaw detail assignment, he was Area Health Educator for the IHS Billings Area, Billings, Montana.

RON FREEMAN, MPH was hired as a tribal employee. He was Director of Planning & Evaluation, Choctaw Health Department from March 1975 to October 1977. Freeman received his graduate training through the Native American MPH Program at the University of California at Berkeley. He later obtained a commission with the USPHS and became Service Unit Director of the Yuma Service Unit, IHS.

was replaced by Calvin Isaac who was the first tribal Chief elected under provisions of the Revised Constitution and Bylaws.

In September 1975, the Tribal Council voted to establish the Choctaw Health Department under tribal administration. It accepted an interim organization plan which merged the IHS direct operations with the tribal operations and provided for a unified organization (the Choctaw Health Department) under the leadership of tribal manager and responsible to the Health Board, the Tribal Chief and the Tribal Council. With the support of Dr. Emery Johnson and Mr. James Meredith, USET Program Office Director, this unique structure was implemented. Through contractual arrangements, several additional services not previously associated with the Choctaw Health Department were assumed: Public Health Nursing, School Health Nursing, Nursing Assistants, Housekeeping, General Maintenance Workers, Food Service Workers. Under the same master contract, the Choctaw Health Department also provided technical consultation and personnel support to the Choctaw Utility Commission.

A major change in the organization of the Choctaw tribal government occurred in July, 1977. At that point, the Tribal Council voted to reorganize its legislative structure. The intent of the Council was to try to strengthen the legislative branch to better meet, or offset, the increased strength of the excecutive branch which was given it by the 1974 Constitution; to better oversee the activities for which it was responsible; and to more clearly define who would assume these responsibilities. Prior to this date, the Council had many committees, some with non-Council members serving as members. The membership and jurisdiction of these committees often overlapped. It was often not clear which group was ultimately responsible for initiating or monitoring a particular activity.

In January, 1978, the Tribal Council established five standing committees: Governmental Affairs, Education, Health, Resource and Community Development, and Budget and Finance. The Budget and Finance Committee was to be chaired by the Secretary-Treasurer of the Tribal Council, a position to which the incumbent was elected by other members of the Council. Similarly, the chairpeople of other committees were also to be elected from the Council by their peers. These committees had defined memberships and plans of operations, and they were all responsible to the parent body, the Tribal Council. In addition to these committees, there existed a Resolution Committee and a Grievance Committee, which met as necessary.

With the establishment of the Tribal Council Health Committee[6], the Health Board was abolished. The Health Committee now has the primary responsibility of providing policy direction for the management and operation of the Choctaw Health Department. The committee is also the direct link between the Choctaw people and professional and paraprofessional staff of the Choctaw Health Department. It, therefore, has the responsibility for making certain that all programs within the Health Department are sensitive to the health needs of the Choctaw people, are delivered in an acceptable and accessible manner, and are provided effectively and efficiently.

In the late seventies, the tribe had gained extensive experience in the management and operation of health services. It was, however, changing its direction from immediate takeover to a gradual, phased-in takeover.

The contracting project suffered a setback when all the managers in the management team acquired in 1975 left at the end of 1977, at almost the same time, either for personal reasons or disagreement with the tribal administration. The tribe immediately searched for replacements.

[6] MAXINE DIXON is a Council member from Red Water. She has chaired the Health Committee since 1978. Before becoming Chairwoman of the Health Committee, she was Coordinator of the Community Health Representatives Program and then Health Coordinator of the Choctaw Health Department. She is currently Public Health Advisor of the tribe. Dixon is very active in national issues relating to the health of the American Indians. She represents the tribe in many regional and national American Indian organizations. She has had tremendous impact on the development and management of the Choctaw Health Department.

The new managers were all direct tribal hires[7]; and the USET Program Office immediately separated its Choctaw Service Unit from the tribal Choctaw Health Department. Administratively, the unified system requested by the Tribal Council and once supported by the IHS no longer existed. Six months later, however, the USET Program Director again requested the tribal Health Director to provide technical direction to the Choctaw Service Unit. Tribal and federal managers continued to work together to stabilize the administration of the Choctaw Service Unit, to recruit physicians, to obtain the recertification of the hospital by the Joint Commission on Accreditation of Hospitals (JCAH), and to achieve the tribal goal of total contracting. From 1978 to 1982, the tribe gradually took over the IHS program by program. It is observed that a vacancy of key personnel in a certain IHS program facilitated the tribal assumption process.

The tribal contracting efforts regained its momentum in 1979, when Phillip Martin was elected tribal Chief. With his support and cooperation, the Tribal Council strengthened its Committee System and specifically the Health Committee. The Tribal Specific Health Plan was completed this year and feasibility studies of contracting were conducted. By the end of 1982, the tribe had already contracted, in addition to all Public Health Programs and some support services programs, many major hospital programs, such as: Contract Medical Care, Dietary, Biomedical, Medical Records, and support services for direct patient care. The Tribe also had personnel in all other IHS Choctaw Service Unit programs, from Nursing, Medical, and Dental to Pharmacy, Laboratory, and Property/Supplies.

In July, 1982, the first proposal to assume total control of all health services on the Choctaw reservation was approved by the Tribal Council and submitted to the USET Program Office. The negotiations were unsuccessful. During FY 83, the IHS suffered a drastic budget reduction and a tribal takeover of all health services at that time did not appear to be a good move. It would have given the general Choctaw population an impression that the budget reduction was a direct result of the tribal takeover. At this point, the USET Program Office appointed a top manager to the IHS Service Unit who had never had any working experience with the IHS or Indian tribes; the harmonious working relationship between top tribal and IHS managers at the CHC deteriorated drastically. The tribe was determined to correct the one-organization-with-two-heads situation with a new proposal for total contracting submitted in July, 1983. After three separate negotiation sessions, the tribe officially took over the management of the Choctaw Service Unit on the Choctaw reservation through 638 contracting. January 1, 1984, was the historic day when all health services on the Choctaw reservation came under the control of the tribe.

Upon completion of all negotiations for the total contracting, Binh Nguyen, who had been working with the tribe for over eight years in various capacities, resigned from the Director of the Choctaw Health Department position to pursue other interests. He agreed, however, to stay on as a Public Health Specialist to assist the tribe in planning activities during the transitional period. The tribe immediately obtained an Interim Director, John Hanley, from the Nashville Program Office through a detail assignment while it was searching for a regular Director. James Cox was selected Director of the Choctaw Health Department in March, 1984 by the Tribal Chief. This appointment was ratified by the Council. Subsequently, an initial meeting of the Hospital Governing Body was convened. In this meeting, the Governing Body adopted its Bylaws and selected its officers. After a long struggle, the Choctaw tribe finally achieved one of its ultimate goals for Self-Determination by substituting tribal control for federal management on the Choctaw reservation. Lists of tribal leaders and Council members who were involved directly or

[7] BINH NGUYEN, a Pharmacist with Public Health experience from overseas and formal graduate training in Public Health from the University of Tennessee (MPH) assumed the directorship of the Choctaw Health Department from 1978 until the end of 1983, when the total contracting project was completed. Nguyen was the key person involved in the strategic planning and operational planning stages of the takeover.

JESSE THOMAS is a Mississippi Choctaw Indian who received his MPH from Tulane University. His graduate training was also sponsored by the Native American MPH Program based at the University of California at Berkeley. Thomas has been Director of Community Health Services, Choctaw Health Department since 1978.

indirectly with the contracting project during the period 1971-1984 can be found in exhibit I of this document.

PLANNING STAGE

The development of the Choctaw Health Department can be divided into three typical planning stages:

1) Policy Planning Stage (1971-1975).

2) Strategic Planning Stage (1975-1979).

3) Operational Planning Stage (1980-1983).

The tribe took advantage of funds available from provisions of different Public Laws to carry out its planning activities.

* POLICY PLANNING STAGE or PRE-PUBLIC LAW 93-638 PERIOD (1971-1975)

During this period, the tribe established its long term goals and objectives to include substitution of tribal control for federal management of Indian reservation. Here, the information system planning model was utilized. It was started with an analysis of health statistics provided by the Choctaw Service Unit as indicated in the tribal brochure Era of Change: "As a result of a Council-directed research into Choctaw health problems during the last year, investigating reports have revealed alarming facts." In early 1972, the Tribal Council received a $15,000 grant from the USET Program Office in Sarasota, Florida, to evaluate health services provided to the Choctaw people by the Indian Health Service. This was a landmark grant from the Indian Health Service to the Mississippi Band of Choctaw Indians. It can be seen as a critical move by both the tribe and the Indian Health Service toward the Choctaw Self-Determination goal. This evaluation gave the tribe an opportunity to gain inside information about the IHS operations and to obtain initial planning tools. Many observations, identified problems, and recommendations are still true and valid today. The recommended emphases on preventive medicine and health education are being stressed in every planning document and contract proposal. The proposed organizational structure were not much different from the current one (see exhibit II). Prior to this evaluation study, the Tribal Council had completed a comprehensive analysis of the entire tribal government structure. This study was funded through the Office of Economic Opportunity (OEO) Self-Determination Grant, and was conducted by Peat, Marwick, Mitchell and Company (PMM). The PMM study was formally adopted as the tribal government reorganization plan by the Tribal Council.

The adoption of this plan by the Council marked its commitment to implement the fundamental structural, procedural, and role changes recommended by the PMM study. This plan, however, provided only a skeletal outline of the new Choctaw tribal government, leaving the details for further study and action by the Tribe. As an immediate result of this study, the health programs underwent a reorganization in 1972, and the Tribal Council Health Committee was later established to replace the Health Board in 1978.

* STRATEGIC PLANNING STAGE (1975-1979)

This stage deals with the conception of possible activities and the creation of means for implementation. Emphasis is on analysis: system analysis, policy analysis, institutional analysis, and the like.

A preliminary evaluation of 638 contracting was conducted by a newly-acquired management team. Upon arrival on the reservation in 1975, this team immediately took control of the Choctaw Health Delivery System, including the IHS Choctaw Service Unit, and worked together to meet the 1976 target date for total contracting of the IHS Choctaw Service Unit. Analyses of personnel status, advantages and disadvantages of contracting, potential problems, and a time table were developed. The plan, however, was never implemented and a proposal for total contracting was not prepared for submission to the Indian Health Service. Instead, in 1977, various grants and contracts funded separately by the USET Program Office were consolidated

under one master contract for the operation of a comprehensive tribal health delivery system, the Choctaw Health Department. At the same time, in an effort to prepare tribal administration for the operation of the total health delivery system and to modernize its management information system, the tribe submitted a proposal and received separate funding from the Indian Health Service for the improvevement of the overall Tribal Management System through developing a Tribal Data System. This Basic Development of Tribal Data System Grant ran from August 1, 1977, through July 30, 1980. The purpose of the system was to more efficiently manage the volume of information that the tribal organization was required to maintain. The four major areas for automated information processing were:

1. Medical Records
2. Property and Supply
3. Payroll and Personnel
4. General Ledger

Unfortunately, this project did not meet its objectives. The following comments from the closeout report of the grant are being shared as a learning experience for those who are planning to set up an automated management system:

"There were several contributing factors to the failure:

1) The company from which the Tribe purchased the computer hardware went out of business almost immediately after the delivery of the equipment.
2) The many software packages that were purchased and intalled were not designed specifically for the tribe's applications and needed a considerable amount of modification. Also, the individual who wrote the software packages was not available to aid in the modifications.
3) Lastly and most importantly, the individual responsible for the Choctaw Data System, [name omitted] was not a qualified data processing manager."

After this first unsuccessful attempt, the tribe continued to commit itself to an automated management system. Under new tribal leadership, the Tribal Council allocated tribal trust funds from timber sales to upgrade the computer system. A qualified and experienced programmer was hired to manage the system. This computer system is now fully operational and in addition to the services provided to the tribal administration and the CHD, it is also providing computer services to other tribal programs and activities.

One of the most important events during this planning stage is the establishment and develcpment of the policy making Health Committee and its subsequently related activities. In conjunction with the establishment of the Health Committee in January 1978, and under provisions of Public Laws 93-638 and 94-437, the Mississippi Band of Choctaw Indians submitted a proposal and received a contract to support activities of the Health Committee.

Three specific tasks of the Health Committee under this contract were:

1. To develop and to approve a Comprehensive Health Plan as required by PL.94-437
2. To develop a strategy for tribal control of the Choctaw Service Unit
3. To obtain legal counsel for the Health Committee and the full Tribal Council on a contractual and consulting basis

As a result of this contract, which was funded separately from the master contract to operate the Choctaw Health Department, a four-year Tribal Specific Health Plan was completed and adopted by the Tribal Council in April, 1979. It was actually a joint effort between the Health Committee and the staff of the Choctaw Health Department. The same planning methods

utilized in the policy planning stage were also applied here:

Statistical analysis
Structural analysis
Observation
Personal interview

During the planning process, health and demographic data were analyzed. Specific goals and objectives of the Choctaw Health Delivery System and each program component were set up with defined outcome indicators. Means or instrumentalities were identified to make the plan operational. A staffing pattern was determined utilizing IHS predetermined criteria (Resource Allocation Criteria).

Possible activities to achieve the contracting goal were examined and outlined in the "Strategy for Tribal Control" document prepared by the Health Committee in November, 1979. The new target date for the total takeover was October 1, 1980. The strategy was also officially adopted by the Tribal Council. But, once again, the tribe decided to delay the date for total takeover due to unfavorable political atmosphere.

* **OPERATIONAL PLANNING STAGE (1980-1983)**

This is the final level of planning in which detailed plans are developed to carry out the strategies outlined at the second level (strategic planning). During this period, many programs not previously contracted by the tribe were contracted. The tribal personnel system was reevaluated and modified along with the pay scale to meet the demands of the around-the-clock operation of the health system. Personnel surveys of federal employees as well as prospective employees available in the local market were also conducted.

With the contracting of the Environmental Health Program, the assignment of federal employees to the tribe under provisions of the Intergovernment Personnel Act (IPA assignment) was utilized. The IPA mechanism, which was not properly developed at the time, was later thoroughly tested and refined. The tribe, at this point, continued to focus on the training and career development of its own members to staff the health facilities. The effort had been begun in 1975 with the New Careers Program funded by the Department of Labor. It was later boosted by the enactment of P.L.94-437. A table depicting the Choctaw health manpower before and after 1976, can be found at exhibit III.

The specific structure of the Choctaw Health Delivery System was finalized in 1982; and the first detailed plan for the total takeover was then developed. A proposal for the total takeover of the remaining portions of the Choctaw Service Unit was submitted to the Indian Health Service in June, 1982. As mentioned earlier, the negotiations were unsuccessful. A second proposal was submitted in July of 1983, with substantial changes; and a contract for the total operation of the Choctaw Health Delivery System was awarded the tribe January 1, 1984.

The development of the Choctaw Health Delivery System through 638 contracting of an existing IHS-PHS Service Unit was very well planned by the tribe. All the appropriate steps were taken. It can be considered a textbook example of planning. One important aspect of the planning process was, however, missing: the needs assessment. The assessment of community needs shifts the emphasis of the Health Delivery System from a service-centered orientation toward greater clientele sensitivity. The needs assessment eventually results in an increased concentration of effort toward satisfying identified service population's needs, which in turn reinforces the health delivery system's transition to marketing for better acceptance. The tribe had hoped to conduct a needs assessment in 1979, during the strategic planning stage. But due to budget limitation and the reduction of personnel, the project was never carried out. The current Choctaw Health Delivery System was designed based on the analysis of statistics generated from the IHS-designed-and-operated Choctaw Service Unit in combination with tribal

demographic data. It focused on the extant clientele and neglected research on the potential of those who had not come to tribal facilities for services. According to the 1982 Demographic Survey of the Mississippi Band of Choctaw Indians, the Choctaw Health Center provided only 37.4% of the health services to the Choctaw poeple, whereas the CHD field clinics provided 15.9%, the County Hospital provided 18.1% and the County Health Department provided 19.8%. These are interesting numbers for the tribe to consider because the majority of resources are currently being expended at the Pearl River facilities.

The tribe is proposing to the IHS to conduct a needs assessment during FY85 as part of the scope of work of the Master Contract. Information from the needs assessment will be utilized to prepare plans for the following 3-year funding cycle (FY 87-88-89).

DEVELOPMENTAL AND OPERATIONAL PHASE

During the past ten years, the Choctaw health delivery system has evolved from a $32,000 CHR program to a multimillion dollar comprehensive health delivery system, the Choctaw Health Department. This is achieved through the gradually phased-in contracting of an established IHS facility with inpatient services combined with the development of new services with resources from IHS, other federal agencies and private organizations. Today, under the direction of the tribal administration, the Choctaw Health Department continues to grow and expand. From a complete isolation from local communities and an absolute dependence on the federal government in the early seventies, the Choctaw Tribe is emerging as a leading provider of employment and services to the Indian and non-Indian communities. The desire of the Choctaw people to live in harmony with the non-Indians and the cooperation received from local communities are unprecedented in this country. Exhibit IV is a detailed description of the Choctaw Health Department. Exhibit V provides a complete listing of funds received during the period documented along with the funding agencies.

There were many interesting details involving the development of a health delivery system through the gradually phased-in contracting of an established IHS facility. It is the opinion of those who were involved in this project that the transfer of a federal facility to tribal management is much more difficult than developing a previously non-existing program. The major activities in the developmental process and/or issues confronted by the Mississippi Band of Choctaw Indians during the developmental and operational phase are outlined in this section in the hope that they will be helpful to those who would like to follow the same or similar paths. The activities and/or issues described in this section are not necessarily in a sequential order and only give the reader an idea and suggestion of how they were done at one location. The situation at each facility should be carefully evaluated before considering any of these activities and/or issues.

1) DETERMINATION OF METHODS TO UTILIZE.

As mentioned earlier in the Planning Stage Section, the Mississippi Band of Choctaw Indians utilized the following universally accepted methods of planning to assess its interests and capabilities:

a. Statistical analysis
b. Structural analysis
c. Observation
d. Personal interview
e. Intake study.

One or more methods can be utilized when considering contracting a certain program component of an IHS Service Unit.

2) DETERMINATION OF PROGRAMS TO CONTRACT AND WHAT WOULD BE REQUIRED TO CONTRACT A GIVEN PROGRAM.

a) Contractible program. The first step is to find out from the IHS which programs are contractible. Primarily, all programs at the Service Unit level are contractible. The office of the Service Unit Director and the position has to be contracted at the same time or after all other Service Unit programs have been contracted. The majority of activities at the Area Office level are not contractible.

b) Program requirements. At this point, the tribe has to determine resources and expertise the tribe may need to assume control of a certain IHS program. In the gradually phased-in method of contracting, the Mississippi Band of Choctaw Indians had the advantage of direct involvement in the operation of the IHS Choctaw Service Unit and obtained all the necessary

information and experience. This approach may not be workable when local IHS officials are not supportive of the contracting efforts of the tribe. Personalities of top tribal managers and federal managers are very important. If they do not work well together, the combined federal-tribal health delivery system will suffer and there will be disruption of services.

c) Funding availability. This is a very important step. The tribe may not want to contract a program which is financially troubled or may want to contract it just because the tribe wants to do a better job at a lesser cost. In reality, the efficiency of a tribal operation is often translated into additional services for tribal members at the same level of funding with the IHS program.

d) Determination of program outcome.

e) Determination of program structure.

f) Determination of staffing.

g) Determination of potential problems including the turnover of personnel.

h) Determination of the availability of appropriate health professionals for the contracted program in the local market for the direct hire option.

i) Determination of personnel option(s) to utilize and identification of IHS staff to retain if applicable.

j) Determination of training and career development needs.

k) Determination of the capability of the tribal organization to provide administrative support to the contracted program(s).

3) TRIBAL PERSONNEL SYSTEM.

Before the adoption of the Revised Tribal Personnel Policies in February 1981, the tribal Personnel System was not geared toward the management of an around-the-clock operation of an inpatient facility. With the adoption of the Revised Personnel Policies, new personnel procedures were developed. The changes in the tribal personnel system during this period is highlighted as follows:

a) Employees' classification. Under the old Personnel Policies, tribal employees were not entitled to overtime pay or any other premium pay. From 1975 to February 1981, employees of the Choctaw Health Department were authorized to receive overtime pay and premium pay through a directive from the tribal Chief. In the new version of the Tribal Personnel Policies of 1981, a new category of personnel was defined—the non-technical, special. These employees are entitled to receive overtime pay and other premium pay. The rates of premium pay are as follows:

Overtime pay:	150% of base pay
Holiday pay:	200% of base pay
Sunday pay:	125% of base pay
Night differential:	110% of base pay

b) Revised tribal pay scale. Before 1981, the tribal pay scale had 15 grades, each grade had 10 steps. The maximum allowable annual salary for a tribal employee was less than $25,000. In many instances, health professionals' salaries exceeded the ceiling. Without a revised pay scale, the tribal administration had to go to the Council with a resolution to receive an exemption for each individual. The new pay scale with 30 grades and 10 steps was adopted in 1981 allowing a maximum salary of $49,000.

c) Adoption of a standardized format for position description and job announcement.

d) Adoption of standardized criteria for employees' classification.

e) Sick leave. At the beginning of every fiscal year, the maximum hours of sick leave an

employee can carry over from the preceeding year was increased from 120 hours to 480 hours. This was designed to avoid the abuse of sick leave and to encourage the employee to save sick leave for extended illnesses.

f) Promotion of wellness. This is a completely new section added to the revised Personnel Policies. To promote better fitness, to improve staff's morale, and to reduce illness, the tribe allows one-half-hour during working day to employees who participated in a regularly scheduled and supervised fitness program which was coordinated by the Choctaw Health Department.

g) Medical/Life/Disability Insurance. From a non-contributory group policy with a very small number of only non-Indian employees participating in it, the tribe developed a fully paid medical, life and disabilility insurance program for all employees. Employees' dependants may be covered at cost to the employee. This excellent package was offered as an incentive to attract quality personnel. It was also designed to offset the rising costs of the Contract Health Service Program.

h) Personnel Survey/Salary Survey. When resource and manpower are available, it is recommended that the personnel office routinely conduct survey on the availability of personnel and the rate of pay in the local market. Many textbooks and personnel materials recommend the Federal Government employment office as a primary source to obtain free information on wage and salary surveys. These surveys, however, are usually set up on a national or regional basis and do not necessary reflect the local trend.

In our experience, the State Hospital Association, the State Public Health Association, the State Board of Health, local hospitals, local health related organizations and local universities are excellent sources for obtaining wage and salary comparables.

4) UTILIZATION OF FEDERAL EMPLOYEES UNDER THE DETAIL OPTION

The Federal Government is an excellent source of personnel to staff a tribal facility contracted from the Indian Health Service. Under provisions of P.L.93-638, a federal employee can be assigned to a tribal organization, and vice-versa a tribal employee can be assigned to a federal agency. For the purpose of this document, we only discuss the assignment of federal employees to a tribal organization.

a. IPA assignment of Civil Service employees.

The Intergovernmental Personnel Act (IPA) of 1970 provides state governments and universities with the opportunity to temporarily exchange personnel and participate in other cooperative efforts with federal government agencies. Public Law 93-638 amends the IPA to make tribal governments eligible to participate in IPA's benefits and programs. The IPA was further amended by the appropriation act for the Department of the Interior and related agencies for the fiscal year ending September 30, 1984, and for other purposes (P.L. 98-146). The IPA assignment of a federal employee may now be extended indefinitely—in increments of two years or less—where it is determined that the assignment will continue to benefit both the executive agency and the Indian tribe or the tribal organization.

a.1) In the contracting of an existing IHS facility, the utilization of civil service employees under the IPA assignments can benefit the tribe in several ways:

a.1.1. Smooth transition from federal administration to tribal administration. The continuity of care can be maintained.

a.1.2. Federal employees can be later phased out through attrition.

a.1.3. Less opposition from federal employees at the critical time when the program is contracted. It also gives federal employees more time for employment search and/or employment adjustment.

a.1.4. Skilled and experienced personnel are readily available to the tribal organization.

a.1.5. Federal employees' job security, salary and fringe benefits are protected by the federal government.

a.1.6. The arrangements are flexible, they can be terminated any time by any party.

a.1.7. With the offer of an IPA asssignment, the federal government can avoid to pay, at one time, a large amount of severance pay at the expense of the tribal contract. Severance payment will not be made when the federal employee transfers or resigns. In this situation, the only compensation the employee received is the lump sum payment for accrued annual leave.

a.1.8. Utilization of federal employees will give the tribal organization adequate time for recruitment, orientation and on the job training of its direct hires.

a.1.9. With an IPA assignment, the tribe has the opportunity to directly supervise and evaluate the federal employee before offering a tribal position.

a.2) Disadvantages of IPA assignment. Any tribe considering the utilization of this avenue of personnel supply should recognize the possible problems with IPA assignments:

a.2.1. The employee may resign, request a transfer or decide to return to his parent organization at any time; therefore, some uncertainty exists.

a.2.2. The cost of the federal employee's salary and benefits is deducted from the base of the funding availability of the contract.

a.2.3. There may be some internal conflicts between direct tribal hires and IPA personnel due to differences in personnel policies, pay schedule and fringe benefits.

a.2.4. When the tribal organization wishes to terminate the IPA assignment and the federal government cannot find another placement for the IPA'd employee, he/she is subject to reduction-in-force and is entitled to severance pay. Currently, contract funds are reduced by the amount of the employee's federal compensation. The tribal organization may find itself in a position of having a position without funding for as long as one year and may not be able to fulfill its contractual obligations with the Indian Health Service. This is one of the weaknesses of the current contracting mechanism. We recommend that the annual lump sum pay and severance pay be considered as additional costs to contracting and should be paid from a special fund. Without a regulatory change, in some instances, the tribal organization may be forced to offer an IPA assignment to an undesireable federal employee.

a.2.5. Incomplete control over the IPA personnel.

A less common method of federal personnel assignment to a tribal organization is the leave without pay option. The Choctaw tribe attempted to use this method but was discouraged by the funding agency. The federal government recommends that this type of assignment should only be used when the detail arrangement is not feasible. In this type of assignment, the federal employee is placed on leave without pay from his/her federal position and receives a formal appointment from, and is paid by, the tribal organization to which he/she is assigned.

b. Detail of commissioned officers.

Under provisions of PL 93-638, a tribe or tribal organization can request the detail of a commissioned officer to its organization. Once a suitable officer is located, a memorandum of agreement can be developed. It is a three-way agreement between the tribe, the officer and the Indian Health Service. It can be cancelled anytime by any party. The Corps is an excellent source of health professionals for any tribal organization.

The officers are on call 24 hours per day and are not entitled to overtime pay; there is no malpractice liability or cost to the tribe; and commissioned officers' qualifications have already been established through a very selective commissioning process.

The tribal organization must pay not only the commissioned officer's salary but also his fringe benefits. The cost for the officer's compensation is deducted from the base of the funding availability for the contract.

Although a commissioned officer can be detailed to a tribal organization for an indefinite period of time, the use of commissioned officer is not intended to meet a tribe's permanent staffing needs. According to current regulations, for every commissioned officer assigned to a tribal organization, the IHS has to guarantee a position and funds for it at the Area Office for the reassignment of the officer in the event the tribe requests the removal of the officer or the professional services of the officer are no longer necessary. Therefore, if the assignment of a commissioned officer becomes unsatisfactory to any party, the removal is easy and immediate. There will be no delay or severance pay involved as they may happen in the removal of a civil service employee.

In the utilization of a commisssioned officer, the tribe must also recognize that:

b.1. The officer remains an employee of the Public Health Service. The tribal organization has very limited control over the officer.

b.2. The tribal organization is not totally responsible for the officer's professional standards.

b.3. The officer may terminate his assignment at anytime.

b.4. The officer and his/her immediate family are eligible to receive health services at the local facility.

b.5. The officer's eligibility for station leave may create some misunderstanding and resentment in the local communities and among other staff of the health delivery system (tribal and civil service).

c. Utilization of National Health Service Corps Personnel.

The National Health Service Corps (NHSC) is another excellent supplier of professional staff for a tribal organization. The NHSC, with its scholarship program provides a substantial number of health professionals to the under served areas including the Indian reservations. For many years, the NHSC scholarship recipients have served in the Indian Health Service programs to meet their payback obligation. An Indian tribe or an Indian organization certainly can go directly to the NHSC to obtain NHSC volunteers or scholarship recipients to staff its facility. There are two different ways to obtain a NHSC assignee:

c.1. Private practice option. Under this option, the tribal organiztion directly employs the NHSC recipient. Currently, all non-profit organizations including private hospitals are eligible to recruit NHSC recipients for direct hire through the private practice option.

c.2. Memorandum of Agreement. Before a memorandum of agreement can be developed between the NHSC and the tribe, the reservation has to be determined as a Health Manpower Shortage Area by the State Health Systems Agency and designated by the NHSC as a NHSC site or sites. Under the agreement, the NHSC will assign its personnel to the tribe to perform certain professional services clearly defined in the agreement. A NHSC assignee is either a commissioned officer or a civil servant. The tribal organization is required to reimburse the NHSC the personnel cost. This is not an actual cost but rather a flat rate established by the NHSC. This rate varies from discipline to discipline. Again, under this option, the tribal organization does not have total control over the assignees but, financially, it is advantageous to the tribe to accept this type of

arrangement for the following reasons:

— The requirement for reimbursement can be waived by submitting a request for waiver.

— The reimbursement rate is generally lower than the actual personnel cost.

On a practical standpoint, the utilization of federal employees has worked well for the Choctaw tribe in the development of its health delivery system. Federal employees on IPA assignment have maintained the stability and continuity of services for the tribal organization. In general, federal employees involved in direct patient care such as physicians, dentists, pharmacists, and nurses accepted the change and the new arrangements exceptionally well. For top management positions, if the tribe decides to use the federal employee option, it must be extremely careful in the selection process to identify the appropriate personnel.

5) DIRECT HIRE OPTION AND THE HIRING OF AN IHS CIVIL SERVICE EMPLOYEE.

To staff a tribal health facility, the following personnel options were previously discussed:

a. Utilization of civil service employees under IPA assignment.
b. Direct hire of civil service employees under the leave without pay option.
c. Utilization of commissioned officers under detail assignment.
d. Utilization of NHSC scholarship recipients under private practice option.
e. Utilization of NHSC assignees under a memorandum of agreement.

Any or all of these options may be utilized by the tribal organization at any time. Again, as mentioned earlier, the utilization of federal employees on detail is not a permanent solution to a tribe's staffing need. The ultimate goal of any professional organization is to have a single personnel system and to directly employ its personnel. Therefore, a tribal organization should seriously consider the direct hire option before considering any other options, especially in those locations where professional staff can be recruited and hired by the tribal organization. When the federal employee option is utilized, the tribe should make every effort to replace them through attrition.

The direct hire option is not being discussed in details in this document. We expect any organization considering the contracting of a health care facility to have some experience in personnel management. The direct hiring of an IHS civil employee is rather special and needs some attention. Public Law 93-638 enables tribes to directly hire IHS employees and allows the tribe to continue to offer the former federal employees civil service benefits, such as retirement, health insurance, life insurance. The employer's contributions made by the tribe on behalf of the former federal employee are reimbursable by the IHS through the 638 contract. In order for a former federal employee to be eligible to retain the federal benefits, the employee must leave the federal government to be employed by the tribal organization without a break in service (or after a separation from service of three days or less). The rate of pay is subject to the tribal classification system and the negotiation between the individual and the tribe. The leave status of the federal employee is affected by the tribal employment. There is no provision or proposal for the transfer of leave credit to the tribal organization. Accrued annual leave is to be paid by the federal government in a lump sum. This amount is deducted from the total funding availability of the contract with the tribe. Accrued sick leave during the employee's tenure with the federal government is held in obeyance during the period of tribal employment, and, at the time of retirement, his/her accrued sick leave (federal) is used, as normally, in determining retirement service credit. If an employee is offered comparable employment with the tribal organization when his/her position is contracted by the tribe and refuses to accept the offer, the employee is not eligible for severance pay. He/she is only eligible for lump sum payment of accrued annual leave.

6) COSTS OF CONTRACTING.

Costs of contracting are often confused by many with indirect costs. Although the majority of contracting costs are allocated to indirect costs, costs of contracting include but are not limited to the followings:

- Indirect costs
- Liability insurance
- Malpractice insurance
- Severance pay
- Annual leave lump sum pay
- Health related legal counsel
- Postage
- Processing of salary and other payment checks.

These additional administrative costs not readily identifiable or previously incurred by the federal government at a higher level than the IHS Service Unit are required to be borne by the tribe in executing a contract. The principal obstacle today to the implementation of PL 93-638 in the contracting of IHS programs is the failure of the federal government to provide adequate contract suppport dollars for tribal administrative costs in connection with health contracts. Since 1975, the Bureau of Indian Affairs has included in its budget a special fund — Indian Contract Support — exclusively for the purpose of paying the cost of 638 contract administration, so that BIA program funds need not be reduced to finance such costs when a tribe exercises its right to take over a program. As reflected in the annual budget requests and appropriations this fund reflects a judgement that section 106(h) of PL 93-638 requires such funding. In its absence, tribes would be required to reduce services as a condition of administering federal programs.

The Indian Health Service, on the other hand, has frequently requested a comparable fund. But it has always been denied by the HHS bureaucracy. Increasingly tribal organizations which contract health programs have been forced to absorb administrative costs through reducing funding availability for health services. This has been the case with the Mississippi Band of Choctaw Indians and other 638-operated facilities.

The problem was clearly demonstrated in a February 11, 1983, letter from the Indian Health Service to the Tribal Chief, MBCI. IHS asserted that administrative funding provided to the tribe reduced the Contract Health Service funds. This funding practice spread the idea that contracting meant a reduction of resources available for health services to the sick and the disabled.

Realizing that the issue of additional funding for the costs of contracting had to be resolved at a level higher than the IHS, tribal leaders brought the issue to the attention of congressional representatives. The House Appropriation Committee in House Report No. 98-257 requested... "The Committee is concerned about difficulties encountered by tribal contractors, particularly with regard to the provision of indirect costs. The committee requests IHS to review its contracting procedures to determine if changes are needed in those procedures and report to the Committee by Feb. 1, 1984. A particular issue that should be addressed is whether a specific line item should be established by IHS to provide indirect costs for new tribal contracts."

In its response to House Report 98-253, the IHS maintained its position that "the problems tribal contractors are experiencing are not the result of the contracting procedures. The problems are, instead, the availability of funds." This assessment was correct. The IHS, however, failed to address the recurring problem of 638 contracting with tribal organizations — the availability of additional funds. In its report, the IHS finally agreed with the tribal interpretation that when a tribe contracts for a program under PL 93-638, "the total funding would include the dollars from the specific IHS program being contracted and an additional amount equivalent to the IHS support or overhead costs such as IHS line managers' salaries, administrative services,

and other management and support activities that are funded through other items in the IHS budget." The IHS conceded that "IHS funding for these activities cannot be reduced proportionately by the contracted program(s) or amount. It may go the opposite direction to actually increase the need for IHS overhead and support." This statement accurately reflects the IHS philosophy toward contracting. It sees a need for more control and better monitoring. Under a 638 contract, the IHS is imposing more restrictions, requesting more reports, and generating more paper work for the tribal contractor. This is why tribes have indicated that they have problems with contracting procedures.

Although the IHS recognized that "there is no utility for tribes to control administrative costs," it has always unrealistically expected tribal organizations to accept a lower-than-negotiated rate in order to avoid a reduction of services.

In the gradually phased-in method of contracting, a contractor can expect to encounter more problems in obtaining additional monies for contracting costs. Every time a new program is contracted, additional monies for contracting costs have to be identified and negotiated. Historically, when the first programs were initially contracted, and depending upon the availability of funds, IHS always added supplemental funds to the contract to cover the costs of contracting. But there has not been a consistent methodology for the allocation of these funds and the determination of a proper amount to be added. Once distributed to a tribal contract, additional funds for contracting costs lose their identity and are distributed between the budget lines Hospitals and Clinics, and Tribal Management. This is the danger of a system without a separate line item for contracting costs. At a certain point, the IHS will arbitrarily determine that the additional funding for contracting costs is adequate and cease to supply additional funds. Later, when additional programs are contracted or additional contracting costs are needed, the tribes will be forced to use funds appropriated for direct health services to cover contracting costs. Also, without a separate line item for contracting costs, tribes may be utilizing monies for direct health services to support the contracting costs without realizing it.

The recommendations of the Mississippi Band of Choctaw Indians on the contracting costs are:

a) During the past few years, negotiations of a contract between the IHS and a tribal organization have been focused on indirect costs and other costs of contracting. There has been very little discussion on health services delivery. To redirect the attention of the contracting efforts toward the delivery of quality health services, the IHS should negotiate a budget only for direct health services. Funding for indirect costs should be determined automatically, utilizing the rate established by the cognizant federal agency.

b) For comparison purposes and for an accurate determination of the funding threshhold, direct and indirect services at each IHS location and their funding level should be clearly identified. If funding level for a certain contract support activity is not available or not identifiable, a methodology should be developed to provide a realistic estimate.

c) The identity and funding level for programmatic, managerial, and contracting costs should be maintained even if IHS chooses not to have a separate budget line item for contract support.

d) A separate budget line item for contract support is the best solution for the contracting costs problem. It is easier to demonstrate to Congress when funding for direct health services is inadequate.

The funding of contracting costs has been a controversy and a problem for the Choctaw tribe during the developmental phase of its health delivery system. The costs of contracting have always been eventually fully reimbursed to the tribe by the IHS. They have been funded with a combination of additional funds for contract support, previous year's program underrun, and,

sometimes, program funds through reduction of direct health services. Although contracting costs have not often been fully funded with additional monies, the contract has brought to the reservation an additional amount of approximately $300,000/year, above the funding level for the Choctaw Service Unit. Without the 638 contract, this additional funding for indirect costs would otherwise be spent elsewhere in the IHS system. The monies have been wisely used by the tribe to strenghthen the tribal administrative system. This is one of the obvious benefits of contracting.

7) LEGAL SERVICE

Under the 1978 contract to support activities of the Health Committee, the tribe retained the services of a Washington, DC, attorney, Mr. S. Bobo Dean, formerly with the Fried, Frank, Harris, Shriever & Kempelman law firm[8]. He had been a legal advisor for the Mississippi Band of Choctaw Indians since the early 70's. The involvement of a consulting legal advisor in the contract negotiations process proved very helpful for the tribe in resolving differences of opinion between the tribe and the IHS, and in avoiding negative confrontations between tribal and IHS administrators who had to maintain good working relationships. Furthermore, the legal counsel provided the tribe with independent interpretations of the law rather than forcing dependence upon those of governmental officials. Legal counsel also provided a direct link between the tribe and IHS offices on matters such as policies, procedures, rules, and regulations. Funding for legal counsel was later extended to the Master Contract and discontinued at the beginning of FY 83 after the tribe's attempt to file a declination appeal. The IHS indicated that the need for legal advice in negotiating P.L.93-638 contracts was questionable, since, under that statute, the tribal and governmental rules are clearly intended to be supportive rather than adversarial.

8) MANDATORY INCREASES, COST OF LIVING INCREASES

Before the declination appeal filed with the Indian Health Service by the Choctaw tribe in 1982, and the subsequent issuance of the Indian Self-Determination Memorandum (ISDM) No. 83-1 (July 29, 1983), there were no written guidelines for an equitable distribution of mandatory increases and cost of living increases between IHS and tribal programs. These monies were previously distributed on a discretionary basis. Following the issuance of ISDM 82-3 and ISDM 82-4, the adding of mandatory increases or cost of living increases to a tribal contract became impossible.

According to ISDM 82-3, at the beginning of FY 82, in order to execute a 638 contract, the tribe had to agree on a contract amount without any mandatory increases or cost of living increases. These increases, for the entire fiscal year 82, became available only at the end of FY 82. Technically, these increases could not be added to the FY 82 contract because the tribe already accepted the lesser amount (without the increases) as the total contract amount. While the FY 82 funding increases could not be utilized to increase the FY 82 contract budget, neither could they be utilized to provide one-time increase for the FY 83 base due to restrictions under ISDM 82-4. With ISDM 82-3 and ISDM 82-4, year-end increases just flowed through the tribal contract. The tribe did not actually receive any year-end increases unless an overrun occurred. With year-end funding available, the IHS would likely reimburse the tribe for the cost overrun.

Fortunately, these discrepancies of the contracting process have been corrected by ISDM 83-1. Mandatory increases and cost of living increases are now being distributed to tribal contractors at the same rate as with IHS direct programs.

9) PROGRAM INCOME

The Social Security Act provides for the eligibility of IHS facilities for Medicare and Medicaid reimbursements. Medicare reimbursements are processed at the local facility but payments are made directly to IHS headquarters by the Medicare program. Medicaid payments are received at

[8] Mr. S. Bobo Dean is currently with the Hobbs, Straus, Dean & Wilder law firm of Washington, D.C.

the local facilities and then sent to IHS headquarters. Medicare/Medicaid payments are required to be placed in a special fund and used by the Secretary of Health and Human Services "exclusively" for the purpose of making improvement in the IHS facilities necessary to achieve compliance with the Medicare/Medicaid or JCAH requirements for certification. Each facility has to submit to IHS headquarters a Medicare/Medicaid spending plan for each fiscal year. The plan must be approved before the monies can be reallocated to the collecting facility.

Under current statute, an IHS facility is not eligible to receive reimbursements for services provided to Indian patients who are covered by private insurance. Income generated from emergency treatment of non-Indian patients has to be deposited with the Treasury and usually not be returned to the collecting facility.

A tribally-operated facility is also eligible for Medicare/Medicaid reimbursements. The income generated, however, is treated differently depending on the ownership of the facility:

a. If the facility is an IHS-owned facility, the income generated through Medicare/Medicaid reimbursements is treated in the same manner as income generated from a IHS facility operated directly by IHS.

b. If the facility operated by a 638 contractor is not an IHS-owned facility, the Medicare/Medicaid reimbursements would be considered as "general program income" to be retained by the tribal organization. General program income is used by the contractor to provide additional health services or benefits within the scope of the current P.L. 93-638 contract.

In addition to Medicare/Medicaid reimbursements, a tribally-operated facility is also eligible for third party reimbursements such as private insurance. The income generated is considered as "general program income" and is retained at the local facility. Again, these funds are to be used to provide additional health services or benefits within the scope of work of the contract. No IHS prior approval of expenditure of general program income is required. The tribe, however, is accountable to the federal government for program income in the same manner required for contract funds.

In the area of program income, it is obvious that a tribally-operated facility has more potential and more flexibility than its IHS counterpart. The distinction, however, between Medicare/Medicaid income generated from an IHS-owned facility and income generated from a non-IHS facility needs more discussion and deliberation. It is the Choctaw tribe's opinion that they should be treated in the same manner and should be retained at the local facility.

10) EQUIPMENT, BUILDING AND FACILITIES

a. Equipment. The transfer of all government-owned equipment needed to operate the Choctaw Health Center from the IHS Choctaw Service Unit to the tribe was initiated when the contract for the total takeover was signed. At this writing, the transfer has not been completed. It is our opinion that the process is too complicated and needs to be streamlined. Title to all property furnished by the government remains vested in the government. Government property utilized by a tribal contractor is regulated by clause No. 12 of the General Provisions (41 CFR + 3-4.6013), and the tribal contractor has the responsibility for purchasing property damage liability insurance.

b. Buildings and facilities. In connection with any 638 contract or grant, the Secretary of Health and Human Services may make existing IHS hospital and facilities available to the tribal contractor or grantee "under such terms and conditions as may be agreed upon for their use and maintenance." This could be a lease agreement or an use permit. The transfer of ownership is not provided for. If ownership is desired by the tribal organization, an Act of Congress is required.

The government is a self-insurer and since the tribe does not hold the title of the facility, it

cannot purchase insurance to protect itself from loss or damage to the Choctaw Health Center, a government-owned facility. In its contract proposal, the MBCI proposed two solutions:

a. A waiver of clause 12(e) of the general provisions, or
b. A stipulation that the tribe shall have no liability to the government for loss or damage to the government facilities except to the extent of any recovery under bonding or insurance where applicable.

11) THE HEALTH COMMITTEE

The structure and duties/responsibilities of the Health Committee were discussed earlier in the Historical Overview section of this document. Empowered by the Tribal Council as the policy-making body of the Choctaw Health Department, the Health Committee played a vital role in the contracting of the IHS Choctaw Service Unit. The Health Committee, representing the legislative branch of tribal government, and the tribal administration, representing the executive branch, act as a check on each other. The Health Committee, due to its composition, is likely to maintain a mixture of council members with seniority and freshman council members and would be able to maintain a certain degree of continuity and consistency in the policy making for the delivery of health services. Without the Health Committee, the Health Department would be subject to drastic policy changes when a new tribal Chief is elected. It is important to note that the Health Committee concept is totally different from the traditional advisory Health Board concept. An advisory Health Board often tries to excercise the authorities not vested in it. It tends to interfere with managerial and policy-making decisions. These activities often develop confrontational attitudes between the advisory Board and the Tribal Council, tribal administration.

Under the current structure, the Choctaw Health Department Director is supposed to discuss policy matters with the Health Committee before they are taken to the Tribal Chief who is the Chief Executive Officer of the executive branch of the tribal government. To avoid confusion, the structure needs to be changed to appropriately reflect the division of power between the Executive Branch and the Legislative Branch. The Director of the Choctaw Health Department should only report to the tribal Chief who is ultimately responsible for all administrative decisions. It is his responsibility to bring policy matters to the attention of the Health Committee and the Tribal Council:

Director CHD → Tribal Chief → Health Committee → Council.

12) COMMUNITY SUPPORT

Besides management capability of the tribal organization, funding availability for the execution of the contract, and the cooperation of the IHS Area Office, another factor in the successful contracting of an established IHS facility is the support of the community people. Local opposition at the early stage of contracting was one reason why it took a decade for the Choctaw tribe to contract the IHS Choctaw Service Unit and to develop the Choctaw Health Department. It was also a reason for the tribe to choose the gradually phased-in method of contracting. By gradually taking over program by program, tribal management slowly gained the confidence of the people through the success of demonstration projects. It was a long but prudent route to total contracting. At Choctaw, the Tribal Council Health Committee was most effective in activities designed to gain community support for total contracting and was instrumental in educating the Tribal Council on 638 contracting. Along with the tribal Chief and the Choctaw Health Department Director, the Chairperson, Health Committee conducted many hearings, workshops and attended many Community Development Club meetings to discuss the tribal contracting efforts.

13) COST UNDERRUN, COST OVERRUN

A cost underrun occurs when the funded amount of a contract is in excess of the actual

expenditures of the program. The savings or unexpended funds can be used to provide additional health services or benefits within the scope of work of the program during the same fiscal year. This policy is applicable to a direct IHS operation as well as a tribal contract.

One major advantage of a tribal contract over IHS direct operation is that, at the end of the fiscal year, program savings can be carried over to the succeeding year. The carry-over of program savings does not reduce the amount that would have been made available to the tribe if there had been no savings or unexpended funds. At an IHS-operated facility, there is no such thing as carry-over of program savings. When the end of a fiscal year approaches and if program savings are materialized, IHS officials usually speed up their regular spending through activities such as travel, training, supplies and hiring of temporary helpers etc. The Area Office or IHS headquarters may pull back expected unexpended amounts and send them to other IHS facilities. After Sept 30, any unexpended funds from an IHS facility go back to the Treasury, a loss to the local program as well as the IHS.

A cost overrun occurs when the actual expenditures of a program are in excess of the funded amount. At the end of a contract year, a tribal contractor, facing a cost overrun situation, has two options to consider:

a. To elect to absorb the cost overrun through other tribal resources.
b. To seek full reimbursement from IHS (assuming that the tribe has a cost reimbursement contract and all the appropriate actions were taken to prevent the cost overrun.) The IHS has the obligation to locate monies for a full reimbursement. If funds are not available from the current fiscal year, funding from the following year can be utilized. Funding level of the contract for the following year is reduced by an equal amount.

Theoretically, cost overrun does not exist within IHS programs. When a local IHS facility faces the cost overrun situation, funds from other IHS locations are reallocated to cover the shortfalls. It may be more advantageous to keep a facility under direct IHS management if continuing cost overrun situations are likely to occur.

14) PROGRAM FORMULATION—DETERMINATION OF PHILOSOPHY AND METHODOLOGY.

In the late seventies, although many health programs had been contracted from IHS and several planning activities had been carried out, the tribe maintained a relatively passive role in the actual delivery of health services on the reservation. Its contracting efforts were limited to prevention activities and supportive services to the IHS-operated direct patient care activities. The contracted programs depended entirely on the IHS-operated programs and were operated basically in the same manner as the initial IHS program.

The tribe started to play a commanding role after 1979 when more new programs were developed with resources from IHS and outside agencies. A complete tribal health delivery system was developed with defined philosophy, methodology and structure.

The tribe recognizes that health is primarily a function of self-responsibility, the main component of good management. Individual dependence on the medical care system and the health care providers will have to be decreased and replaced by wellness and self-help approaches to health. If the Choctaw Health Delivery System is to achieve its stated goal of elevating the health status of the Choctaw people to the highest possible level, it has to successfully persuade individuals to take responsibility for their own health and to adopt health oriented behavior.

Keeping this in mind, the Choctaw Health Department, on one hand, is designed to provide quality health care services in an acceptable and accessible manner to the Choctaw people. The impact of such a curative system on the health status of the Choctaw population is relatively

small, however, when compared to that produced by changes in lifestyle and environment or by preventive activities such as immunization, periodic screening/ examination, and health education. Therefore, on the other hand, the Choctaw Health Department is focusing on prevention and wellness approaches. It actively seeks community involvement and individual self-responsibility in health care. It stresses the cooperation and assistance of the family, the community, the school, the individual, and other tribal, federal programs to improve physical, social and psychological dimensions of the environment. The traditional relationship between patient/health care providers has been passive with regards to both patients' and providers' roles. A more dynamic relationship must be established. When receiving treatment at the Choctaw Health Center, in the communities, or at home, individuals should expect to receive counseling and education on the behaviors they can adopt to help reduce risk. In return, providers should strive to provide adequate information in order for the individual to make his own decision. The target population of the Choctaw Health Department is not only the sick and the disabled, but also healthy individuals.

In the delivery of health services, the Choctaw Health Department utilizes the team approach. Program components are integrated to avoid distinction between curative and preventative programs. Quality health service is not the responsibility of a single person or a single program, but a joint effort between the patient, the health care providers (from physician, nurse, pharmacist, to counselor, outreach worker, etc.), and all program components of the Choctaw Health Department.

15) PROGRAM FORMULATION—DESIGN OF THE CHOCTAW HEALTH DELIVERY SYSTEM

In general, three approaches are dominant in the design of a health delivery system:

Classical Approach
Behavioral Approach
Contingency Approach

The classical approach is perhaps the most widely accepted by managers of primary care programs. Under this approach, managers are responsible for defining policies, assigning responsibilities and ensuring staff performance accountability. Emphasis is on a set of management principles that, if followed, will enhance overall program performance. Its limitation, however, is an inability to effectively deal with the unforeseen and unanticipated human problems associated with health care delivery. It also tends to overlook the role of informal groups in supporting or inhibiting the achievement of organizational goals. The classical approach also offers a ready explanation for problems of innovation. Here, difficulties are typically attributed to "red tape" and the structure's failure to respond quickly to environmental demands.

In the behavioral approach, design focuses on fundamental assumptions about individuals within the organization. The emphasis is on the expectations of individuals within the program. This approach easily leads to selective inattention to the structural aspects of the program. Personality, individual interests and professional inclinations tend to dominate program objectives.

The contingency approach is the logical outgrowth of the classical and the behavioral orientations. Here, the design attempts to achieve a balance between community and program characteristics as well as between individual and program characteristics. When this balance occurs, there is an expected positive effect on the overall performance of the individuals, the work unit and the organization.

The Choctaw Health Department was designed with the contingency approach in mind. It is a prevention oriented program with an inpatient facility and a decentralized primary care

network (three satellite clinics.) In the organizational structure, the hospital does not appear as a separate unit. It is integrated with other components of the Choctaw Health Department. The reason is to avoid a conflict between hospital care and prevention/primary care. The Director, Choctaw Health Department, occupying a boundary role between hospital programs and primary care/prevention programs is responsible for reconciling or controlling the possible conflicts between these programs.

As mentioned earlier in the operational planning stage, the 1982 Choctaw Demographic Survey indicated that many community people did not use services provided at the Choctaw Health Center. The distance between Pearl River and other communities and transportation problems may be interpreted as the major reasons for the under utilization of the CHC. The majority of the survey's respondents who indicated a county facility as their primary source of health services are from communities without a tribal health facility such as Bogue Homa and Crystal Ridge. The current structure of the Choctaw Health Department does try to respond to the local needs by decentralizing its system with three satellite clinics although funding for these activities are diminishing from the IHS budget. The field clinics are being partially supported by the National Health Service Corps through a Memorandum of Agreement and the placement of health professionals such as physician and dentist. Unfortunately, resources from the NHSC are also about to dry up. The primary care program at the field clinics, in addition to meeting the health care needs of the local communities, is also utilized as a vehicle to present the prevention and wellness concepts to the communities. The existence of the field clinics is very important in order for the Choctaw Health Department to carry out its mission. Again, it is time for creative planning for tribal planners and administrators to maintain services at the field clinics.

16) BUSINESS OFFICE AND THE CONTRACT HEALTH SERVICE PROGRAM

The Business Office of the Choctaw Health Department was established in 1981 when the Contract Health Service Program was contracted. The then IHS-operated program was plagued with serious administrative problems:

- Inadequate funding
- Poor management decisions
- Poor record keeping
- Ineffective handling of payment requests
- Excessive delay in the processing of payment checks.

In 1980, the IHS-operated CMC program was facing investigations of local congressional representatives. Many local hospitals and health care providers cancelled their contracts with the Indian Health Service and cut off services to the Choctaw people. On a programmatic standpoint, it was not an appropriate time for the tribe to contract the CHS program. Realizing, however, that the Choctaw people are the ones who suffer the consequences of the mismanagement of local IHS personnel, the tribe made an exceptional effort to contract the CHS program. Another motive for the contracting decision was probably the indirect costs issue. During fiscal year 1981, the tribe lost several federally-funded programs due to congressional funding reductions. With the IHS allowing the full indirect costs rate applied against the $800,000 funding base for the CHS program, the tribe expected to generate adequate funds for the indirect costs pool without having to drastically increase the rate or to lay-off administrative personnel who were employed under the indirect costs budget.

Prior to the tribal takeover of the CHS program, the IHS Service Unit had three clerical positions dealing with financial matters which worked independently and separately: the Contract Medical Care Clerk, the Finance Clerk and the Billing Clerk (temporary). In the initial assessment made by the Director of the Choctaw Health Department, it was determined that the Contract Medical Care Clerk needed professional support and back-up help from other clerks. The Business Office was designed to operate the Contract Health Service Program in a business-

like manner with all financial clerks sharing one office area and sharing some office duties. A full-fledged Business Office was to be developed in four different phases:

Phase I: Have the CHS Program organized and operational (FY81)

Phase II: Assume Medicare, Medicaid Billing duties (FY82)

Phase III: Collect reimbursement from private insurance (FY84)

Phase IV: Assume duties for budget planning and financial management (FY85)

During its first year, the Business Office was staffed with a Business Office Manager and a Contract Health Service Clerk to operate the CHS Program. With the newly-established Business Office, the Choctaw Health Department quickly regained the confidence of local health care providers and successfully negotiated new contracts at substantially lower rates. One primary provider, the F.G. Riley Memorial Hospital was so pleased with the arrangements that it has not raised its negotiated per diem rate since 1981.

Further examination of the IHS Service Unit indicated that the Medicare/Medicaid Billing program was for all practical purposes inactive. No claims were submitted during FY 80. During FY 82 contract negotiations, the tribe volunteered to assume the billing responsibilities for the IHS Choctaw Service Unit without any additional funding from the IHS. A Billing Clerk position was added to the Business Office utilizing savings from other contracted positions that were being budgeted at a lower rate than their federal counterparts. Plans are presently being made to add an insurance clerk to the Business Office to handle insurance claims.

The takeover of the Contract Health Service Program was a very important step in the Choctaw contracting process. The success of the Business Office gave the Tribe the needed confidence that it could manage one of the most complicated and troublesome programs of the Indian Health Service and had greater ability to deal effectively with local hospitals and local health care providers than had the IHS.

17) REDESIGNATION OF DUTIES AND REASSIGNMENT OF EMT'S

The ambulance service is not a traditional IHS-operated program. It has been operated since its beginning in 1977 by the tribe with funding from the CHR program. This program has three fulltime EMT's. Before the 1981 reassignment, ambulance service was part of the Transportation program. The reassignment is being described as an example of program adjustment after the initial setup by the tribe and is a clear indication of a better utilization of manpower and resources. The Choctaw Ambulance Program averages about 350 ambulance runs/year or approximately one run a day. It was determined by the management that it was not a cost-efficient operation. In 1981, the position description of the EMT's was rewritten with the title changed from Emergency Medical Technician to Medical Technician/EMT. Many Nursing and other duties were added to the position description: taking vital signs at outpatient clinics, providing bedside care and inpatient therapeutic procedures, performing duties in the emergency room, and serving in interpretation, security, orderly, etc. After the new position description was established, the EMT's were tranferred to the Nursing Department and were directly supervised by the Director of Nursing. These arrangements gave the shorthanded Nursing Department additional help and the EMT's became more productive, leading to more job satisfaction.

18) FACILITY OPERATION

The Maintenance program of the IHS Choctaw Service Unit was contracted by the tribe in 1978. The IHS Maintenance Supervisor retired when the program was tranferred. The Maintenance Supervisor position of the IHS system that required very little technical skills was converted into the Facility Manager position that requires an Engineering degree (BS).

The personnel cost of the tribal position is actually less than that of the IHS Maintenance Supervisor. But the fact that at the time of his retirement, the IHS Maintenance Supervisor had many years of service with the IHS should not be ignored.

The tribal Facility Manager, an electrical engineer, has been a great asset to the Facility Operation Branch of the Choctaw Health Department. An energy management system was designed and installed at the Choctaw Health Center during 1982. The projected annual cost savings is approximately $42,000/year. A solar system was designed and is being installed to provide hot water to the Health Center.

19) EMPLOYEES' MEAL PROGRAM

The Dietary Department and the Choctaw Health Center have adequate staff and facility to provide meals to the staff working at the Choctaw Health Center. Under IHS management, this could not be provided on a regular basis because monies collected from the sale of meal tickets had to be returned to the U.S. Treasury and were considered as a loss to the program.

After the contracting of the Dietary Department, the employees' meal program was established. It provides hot and nutritious meals to the staff at cost. This program provides convenience and boosts the morale of the employees.

20) HEALTH EDUCATION/RISK REDUCTION PROJECT

The Health Education Risk Reduction project was initiated in 1980 with funding from the Centers for Disease Control channeled to the tribe through the Mississippi State Board of Health. It was a two-year demonstration project with activities such as:

a. Implementation of the School Health Curriculum Project at BIA schools. This project was aimed at the 5th and 6th graders and focused on the human body systems and functions in order to increase awareness in health maintenance and disease control and to better equip the students at an early age with knowledges to make intelligent decisions about health styles.

b. Implementation the New Hampshire Biofeedback project at Choctaw Central, grade 6-12. This project is based on the concept that (positive) changes in attitude and behavior will occur when students see the immediate (negative) changes that take place in the body after only one cigarette.

c. Employee fitness program. This program was designed to improve general health and morale and productivity of employees.

d. Choctaw Five-Mile Run. This event was designed for the annual Choctaw Fair with the same purpose as the employee fitness program, but directed toward the general population.

e. Health Risk Appraisal Project. The project is based on the theory that an accurate assessment of one's own risks serves to pave the way for positive decision making regarding the maintenance of health, enhancing behavior and the reduction/elimination of illness producing behavior. Computerized appraisals were completed on tribal employees and community residents.

These five activities when taken together constituted a health education effort aimed not only at reducing the incidence of morbidity and mortality on the reservation, but also at generating the belief that the individual has control over his health and, ultimately, his life.

Funding for the Health Education Risk Reduction Project is no longer available and the project ceased to operate in 1982. It is, however, still creating behavioral changes and long-term impact on the reservation. It has generated an on-going enthusiasm in exercising, running, etc. Runners' clubs are still active in many communities and their members continue to participate in statewide running events.

21) SECURITY SERVICE

During past JCAH surveys, one of the deficiencies cited repeatedly by the Joint Commission on Accreditation of Hospitals was the (lack of) security services at the Choctaw Health Center. With funds available from Medicare/Medicaid reimbursements, the Choctaw Health Department created three security guard positions. Security service is intended to provide security to the patient as well as the staff. To better manage security services on a 24-hour basis, the guards are assigned to the tribal security pool which, in addition to the health facilities, is also responsible for the security of all other tribal facilities and tribal enterprises.

22) PARTIALLY SELF-PAID EYEGLASSES PROGRAM

Prior to the establishment of the tribal eyeglasses program in 1980, vision examinations and eyeglasses were provided to patients through IHS puchase orders. The patients were referred to an outside optometrist for examinations. The private practitioner was reimbursed at the prevailing medicaid rate. This type of setup was acceptable until 1979, when special funding for eye examinations and eyeglasses diminished. The only resource for a patient to obtain eye examinations and/or eyeglasses is the Contract Health Service Program.

Unfortunately, it was nearly impossible to obtain an eye examination and/or a pair of eyeglasses through the CHS program since funding for this program was limited to priority I, which included only emergency situations.

At this point, the tribe decided to set up a partially self-paid eyeglasses program at the Choctaw Health Center to provide this much needed service. A refraction unit was purchased with program underrun monies. A part time optometrist was hired. This position was created through savings from other contracted positions the tribal pay rate of which was lower than the IHS funded base. The program provides vision examination, diagnosis and optometric treatment of any vision anomalies referred to it by other professionals. Services include duplication of patient prescriptions from glasses that have been worn by the patient, prescription verification, dispensing, frame adjustments and patient education. Eyeglasses can be obtained through several different sources:

a. Self-pay. Eyeglasses are ordered for the patient at cost. The Choctaw Health Department offers a large selection of stylish frames. Photogrey lenses not previously available are now available. Plans are being made to offer contact lens services.

b. New Eyes for the Needy. For those patients whose income falls below the proverty level, eyeglasses are being provided through vouchers provided by the New Eyes for the Needy.

c. Bureau of Indian Affairs. Funds are also available from BIA school to provide eyeglasses to a group of students who participate in the Intensive Residential Treatment Program.

The self-paid concept has been very well accepted by the Choctaw communities. The patients are exceptionally satisfied with the program. Its success proves that the patients do not always expect free service. The deciding factors for satisfaction are consistent with any other groups:

a. Quality of service
b. Convenient location
c. Reasonable price

23) HEMODIALYSIS TREATMENT FACILITY

The hemolysis treatment facility at the Choctaw Health Center is a limited care facility. It is an example of a successful and cost-effective joint venture between the Tribe and a non-profit organization outside the IHS and the federal system.

The main purposes of the project were:

a. To provide quality services at a convenient location to the kidney patients.
b. To better utilize the unused spaces at the Choctaw Health Center.
c. To reduce to a minimum the cost of providing hemodialysis treatments to kidney patients.

The project was initiated in April, 1982, through negotiations between the Choctaw Health Department Director and Dr. Bower, President of Kidney Care, Inc. The Nashville Program Office was later involved in the preparation of a revocable license to authorize the tribe to use the federal facility for this purpose. The 638 contract was amended to include the added scope of work and to authorize alterations to the facility. The Kidney Care facility was opened to patients in June, 1983, to initially provide hemodialysis treatments to Indian patients who are eligible for IHS services.

The incidence of Choctaws with chronic kidney disease is approximately two or three times the national average. Before the establishment of the the local facility, kidney patients had to travel three times a week to Meridian or Jackson to receive the treatments which are paid for by Medicare, Medicaid, private insurance and/or IHS Contract Health Service funds.

The Choctaw Health Department utilizes unused spaces provided by the IHS under a revocable license as a in-kind contribution to establish the Kidney Care Facility operated by Kidney Care, Inc.

Kidney Care Inc. is responsible for the management, technical supervision and quality assurance of the facility. In addition to the physical facility, the Choctaw Health Department also provides the following supportive services to the hemodialysis facility at the Choctaw Health Center: telephone, utilities, housekeeping, groundkeeping, general maintenance, laboratory support, emergency room back-up and ambulance service.

For services provided at the Choctaw Health Center, Kidney Care Inc. is reimbursed by Medicare, Medicaid and private insurance. There is no money transaction between the tribe and Kidney Care Inc. The Choctaw Health Department no longer has to use Contract Health Service funds to pay the balance after Medicare or insurance reimbursements or to pay in full for services to patients who have no other alternate resources.

This five-unit Kidney Care facility is currently open to non-Indian patients. It has greatly improved the well-being of the kidney patients and generated an annual saving of approximately $70,000 in CHS funds which are utilized to provide other needed contract health services.

24) THE JCAH GOVERNING BODY

To meet the contractual obligation that the contracted inpatient facility is certified by JCAH, a governing body has to be set up for the contracted facility.

The determination of composition of the Choctaw Hospital Governing Body was not an easy task. On one hand it has to meet JCAH standards. On the other hand, it must not create any conflicts with other tribally-mandated policy making bodies and/or the established tribal administrative structure and/or established tribal policies/procedures.

The following makeup of memberships is a suggestion of a tribal hospital governing body that meets all requirements of a complicated situation:

a. Voting members:

- Tribal Chief or Vice-Chief or Designee (Chairman).
- Members, Health Committee (5).
- Director, Choctaw Health Department.
- Medical Director-Chief Medical Officer.
- Director, Clinical Service.

b. Ex-Officio members:

— Director, Nashville Program Office or Designee.
— Other officials as deemed appropriate.

In accordance with JCAH requirements, a hospital governing body has the overall responsibility for the conduct of the hospital in a manner consonant with the hospital's objective of making available high-quality patient care. It has the responsibility of appointing the Chief Executive Officer for the hospital. In the Choctaw Health Delivery System, the Chief Executive Officer for the hospital is the Director of the Choctaw Health Department who is assisted by the Director of Clinical Service.

The Governing Body emphasizes the development of an effective and appropriate institutional planning process. In doing so, the Governing Body periodically examines the hospital's mission or purpose, and its goals, policies, and current programs. It approves an overall plan and budget that reflects the annual operating budget prepared by management. A three-year capital expenditure plan for the hospital will be developed that identifies the anticipated sources of financing for, and the objectives of, each proposed capital expenditure, as provided under applicable federal, state, and local laws and regulations. The overall plan and budget will be reviewed and updated at least annually. In developing the overall plan and budget, the governing body, through the Director, Choctaw Health Department and the Director, Clinical Service, will establish a planning process within the hospital through which:

— areas of need are defined and analyzed,
— general goals that relate to each need are established,
— specific objectives are set to meet the general goals,
— alternative courses of action are identified and selected,
— and, provision is made for implementation of the plan of action and for evaluation of the effect of program activities.

The overall plan and the budget shall reflect the coordination of hospital's services with those of other health care facilities and related community resources. Plan to initiate, continue, expand, reduce, or discontinue a specific service should be based on a documented determination that the proposed plan represents the most effective available method for defining and meeting the health needs of the community.

All these responsibilities are delegated to the tribal Chief and the Health Committee by the Tribal Council. The Governing body of the Choctaw hospital, with nine (9) voting members who all have a vested interest in the health delivery system, meets all JCAH requirements. At the same time, it does not create any conflicts with the established Health Committee and Tribal Administration.

The tribal Chief, as Chairman of the Governing Body, has the final authority to appoint the Chief Executive Officer of the hospital who is subject to the ratification of the Tribal Council.

The Health Committee, with five voting members on the Governing Body, has the majority of votes and controls the Governing Body. It continues to maintain its authority as a policy-making body for the Choctaw Health Department as delegated by the Council.

The Governing Body receives professional input from three health professionals: the Director, Choctaw Health Department; the Director, Clinical Service; and the Medical Director/Chief of Staff.

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The gradually phased-in approach to contracting has been an ideal contracting method for the Choctaw Tribe and the Indian Health Service at the given time when either one of these organization were not really ready for the total contracting of an established IHS inpatient

facility. The phased-in method provided the tribe and the IHS with the opportunities to learn from mistakes and to improve the contracting mechanism.

In this section, all major issues and problems relating to 638 contracting were discussed along with operational activitities which were different with traditional IHS programs or did not exist in the IHS system. Traditional IHS programs that were being operated by the tribe in the same manner, with the same staffing pattern were not discussed.

With the exception of the costs of contracting issue, the majority of problems with 638 contracting have been satisfactorily resolved. Any tribal organization considering a 638 contract of its health care facility would be much better off today than it would have been two years ago.

THE FUTURE

In its contracting endeavor, it has never been the intention of the Choctaw tribe to merely replace the IHS in the management of the Choctaw Service Unit, and to provide the same types of services within the same constraints of federal guidelines. It always wants to do a better job and provide more services to its people. In addition to the quality, quantity and accessibility of health services, tribal leaders are approaching health services delivery as an opportunity for economic and employment development for the tribe.

It is certainly a mistake for any tribal government seeking to develop tribal institutions aimed at achievement of economic self-sufficiency not to consider the health care industry. This $400 billion/year industry is definitely as important as any other industry. More importantly, on the majority of reservations, the basic structure, the facility and resources for the delivery of health services are readily available from the Indian Health Service. It is still too early to determine the positive impact of the 638 contract on the health delivery system on the Choctaw reservation. There have been some minor administrative problems and there will be more problems. But the potential is here, with the contract. We have all the indications that the future is bright.

1. **Nursing Home Project.**

After the total takeover of the IHS Choctaw Service Unit in January, 1984, the next goal of the Mississippi Band of Choctaw Indians is to set up a Nursing Home on the reservation as part of the Choctaw Health Department's operations. A 60-bed facility to start with, the Choctaw Nursing Home will be designed with all supportive facilities ready for an expansion to 120 beds.

The primary goal of the planned Nursing Home is to meet the Nursing Home need of the Choctaw people. In order to assure, however, that the facility can be operated efficiently, it will be opened to the general public. The target date for the grand opening of this facility is being planned for fall, 1985.

Choctaw patients currently in non-tribal nursing homes are at considerable distance from their families and friends. Since most of them speak little English, they are, in a sense, confined to an alien culture and "culturally abandoned." Many other members of the tribe whose conditions require nursing care resist these facilities and remain, to their physical detriment, at home. Substandard housing and sanitary conditions in the home in many instances do not allow utilization of home health service and dictate nursing home placement.

The facility will be constructed with monies borrowed from a lending agency or funds generated from the issuance of tax-exempt bonds. It will be an income-generating facility. In addition to the creation of 50 new jobs with an annual payroll of $500,000.00, the income generated by the Nursing Home will be utilized to support a half-way house for alcoholism rehabilitation. This, in turn, will create more employment.

The Nursing Home is also a testing ground for the opening of the Choctaw Hospital to the general public. The Kidney Care facility is currently the only outpatient facility where Indians and non-Indians are sharing services. The Nursing Home will be a further integration of non-Indians into an Indian facility.

In the future, when the hospital is actually opened to the general public, the Nursing home would be part of the marketing strategy. Its patients may be admitted to the hospital and can be utilized to attract their relatives and friends to come for services.

2. Provision of health services to non-Indians.

The fact that the inpatient facilities at the Choctaw Health Center are underutilized has long been recognized by tribal leaders. During the past three years, the Choctaw Health Center has had an average occupancy rate of about 38%. It consistently provides approximately 4,800 inpatient days/year versus a full capacity of 12,775 days/year. Its facilities are fully-staffed to

provide care to 35-40 inpatients/day. To better utilize its resources, the tribe is determined to correct the situation. The general concept of extension of health services to non-Indians on a fee-for-service basis has been discussed. This additional income can be utilized to:

a. Upgrade current services and staffing.
b. Retain, recruit, and develop professional staff.
c. Establish additional, specialized services.

The following solutions are being suggested for future planning and direction. Further investigation and study are needed before a final decision is made:

a. Convert the Choctaw Health Center into a Health Maintenance Organization (HMO) for tribal employees and employees of other tribal enterprises. The Choctaw Health Department can be utilized as the administrator of the self-insured health benefits plan with direct and referral services provided through the Choctaw Health Center. The HMO concept can be later introduced to other major employers in the area.

b. Provide health services to the general public on a fee-for-service basis.

c. Develop close ties with the University Medical Center for quality assurance as well as physician recruitment purposes.

d. Avoid direct competition and/or conflicts with local health care facilities and/or providers by specializing in service areas that are not currently available locally including:

— Psychiatric care.
— Alcoholism treatment and rehabilitation.
— Promotion of preventive medicine practices and wellness concepts.

These services can be developed from the existing structure and staffing with minimal adjustments and capital investments. There will be a need for reorientation of current staff and recruitment of additional staff. The opening of the Choctaw Health Center to the general public will be introduced to the local medical community as a supplementary to the existing services rather than a competition.

e. Grant staff privileges to local physicians and invite them to admit patients to the Choctaw Health Center.

f. Develop an agressive marketing plan with a full time marketing specialist for active community relations. In its marketing efforts, the management will pay equal attention to the staff at the Choctaw Health Center. Disunity among members of the staff must be avoided in the development of a marketing strategy. The introduction and legitimization of new marketing functions aimed at improved patient and community acceptance, sometimes, tends to alienate health professionals who continue to view their activities purely as maintaining the status quo. Management must embark on a highly diplomatic and low-key educational program within the Choctaw Health Department in order to win support for innovative ideas.

g. The Kidney Care facility and the Nursing Home will be considered as important parts of the overall marketing strategy.

h. Direct the marketing of outpatient and general medical services westward, toward the Edinburg community.

SUMMARY AND RECOMMENDATIONS

With the exception of the contracting costs issue that remains to be resolved, contracting regulations under provisions of P.L. 93-638 are much more favorable for tribal contractors now than ever before. In many aspects, a contracted program is treated equal with IHS-operated programs. Although the gradually phased-in method of contracting worked well for the Mississippi Band of Choctaw Indians, it may no longer be the ideal method for today's contracting since many contracting obstacles have been removed. If the Choctaw tribe had to do it all over, it might not use this same method. If the same method were used, it would probably take less time to carry it out. But when a tribal organization is unsure of its capability to assume management responsibilities of an IHS facility or if the level of opposition to contracting is high, the gradually phased-in method is still the recommended method. Again, it is the opinion of those who were involved in the contracting efforts of the Choctaw tribe that developing a tribal health delivery system from an established IHS facility is much more difficult than developing a totally new system. The only difference between taking over an inpatient facility and taking over an outpatient one is that, with an inpatient facility, the tribe has a lot more responsibilities. It needs more skills in personnel management and recruitment because it is going to deal with a larger group of highly sophisticated and demanded health professionals.

Currently, many tribes are still fearful that Self-Determination contracting is the beginning of the self-termination of health services. There is no logic for this chain of thought. While the termination of health services is a possibility, it would require an Act of Congress to do so and when it happens, it is likely to happen to any or all programs no matter whether they are contracted to Indian tribes or remain with the Indian Health Service. Better yet, a tribe with a 638 contract can use indirect costs monies (even if not fully funded) to strenghthen its administrative system and would be ready to cope with the difficult situation when resources for the IHS are reduced or terminated. Some advantages of a 638-contracted facility are:

1. Greater sensitivity and rapid response to local health needs.
2. Better position to obtain assistance from private sector and non-profit organizations. These agencies are not likely to provide financial support to the IHS, a federal agency.
3. Increased revenues through third-party reimbursements for services provided to Indian patients that can be collected and retained at the local facility.
4. Better utilization of manpower and resources by developing new services and/or providing services to non-Indians when the facility is underutilized.
5. Increased revenues through the provision of health services to non-Indians on a fee-for-service basis.
6. Utilization of professional expertise of current staff to develop income-producing health services such as Nursing Home facilites that an IHS Service Unit is currently not allowed to be involved in.
7. With added services and increased services utilization, tribes can enjoy the savings of volume-purchasing and resource-sharing. For example, many services can be shared between the inpatient facility and the nursing home such as: Dietary, Housekeeping, Maintenance, Groundkeeping.
8. Favorable conditions for tribes to develop comprehensive plans for training, upgrading, and career development for tribal members.
9. Better job opportunities for tribal members in the health field provide more incentive for students to get into health professions.

Once a tribe is determined to contract for the management of its health care facility from the

IHS, it should proceed with care. It should take every precaution to assure that the quality and the continuity of services are maintained. A summary of experiences and recommendations from the Choctaw contracting efforts are described below:

1. A successful tribal health delivery system requires an absolute commitment to the quality of care. There should be no political interference in the delivery of health services.
2. A policy-making body similar to the Choctaw Tribal Council Health Committee is strongly recommended to maintain a certain degree of consistency in policy and direction for the delivery of health services, especially when a new tribal chief executive officer is elected.
3. There are many risks involved in the management of a health delivery system especially when direct patient care and inpatient services are involved such as medical, legal and administrative liabilities.
4. In a cost overrun situation, when additional funds are needed from the IHS, IHS-operated programs will have priority over tribally-contracted programs.
5. Tribal contractor must understand the IHS system and how it works.
6. It is advantageous to understand the governmental and IHS budgetary process.
7. Congressional representatives play a key role in resolving problems or matters related to budget and policy direction of the IHS. It is very important for tribes to obtain their support no matter if it is going to contract the IHS facility or not.
8. Many tribes have experience and expertise in different areas of self-government and health care management. Tribes should maintain a close relationship and develop a system to share information and experience.
9. There are many organizations outside the federal government and the IHS that are interested in providing financial or technical assistance to Indian communities. Tribes should identify and use these resources.
10. Currently, there is no incentive for tribes to contain indirect costs but full reimbursement of indirect costs to the tribe may reduce funding for direct health services. Tribes with internal resources may elect to accept a lower-than-negotiated rate to keep funding for health services intact. For tribes without internal resources, the best solution is to obtain full contracting costs funding from IHS through a separate budget line item for contract support.
11. Without adequate funding for costs of contracting, tribes are being forced to offer employment or IPA assignment to undesirable IHS employees.
12. The attitude of IHS officials at the Area Office toward contracting is very important in executing a 638 contract.
13. When the gradually phased-in method of contracting is utilized, there may be disruption of services when the tribal contracting efforts are not supported by local IHS officials.
14. During the contracting process, open communication and dialogue should be developed among tribal administration, Tribal Council, and tribal members.
15. Personnel management is one of the most important aspects of program management. The tribal personnel system should be fully-developed to accomodate the complicated health care management system.
16. There should be a good fringe benefits package and a well-designed merit system for personnel recruitment and retention purposes.
17. The reputation of the tribe as a stable and non-discriminatory employer is very important

in the recruitment and attraction of quality health professionals.

18. The federal government is an excellent supplier of health professionals for initial staffing needs of tribal facilities.

19. The utilization of federal employees on detail is not a permanent solution to a tribe's staffing needs. Where and when possible, it is recommended that the direct hire option be utilized.

20. It is strongly recommended that the top manager of the tribal health delivery system be a direct hire. This individual is very important to the success or failure of the contracted health system including the acceptance of the new system by tribal members. This person must possess technical expertise, thorough knowledge of the tribal system, and knowledge of the IHS system. Most importantly, he/she must be able to gain support, confidence, and respect of the tribal chief executive officer, tribal administration, the governing bodies (Council, Health Committee...), the staff, and the people.

21. A comprehensive plan to recruit, and train tribal members in health professions is a must to meet the permanent staffing needs of the tribe and to curb the high rate of staff turnover.

22. In comparison with other non-federal organizations and the private sector, physicians are in perhaps the only discipline in the IHS system that is underpaid. Tribes with 638 contracts are inheriting the same problem from the IHS due to funding availability. This is one of the reasons for the high turnover of physicians on the reservation. An incentive plan tied in with patients load should be developed. Financial compensation for productivity can be made possible through increased revenues received from third-party reimbursements or reimbursements for service provided to non-Indians.

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It is unquestionable that the Mississippi Band of Choctaw Indians believes in the value of 638 contracting. The experience gained by the Choctaw tribe in its contracting efforts is useful to any tribal organizations considering a 638 contract to assume control of an established IHS facility. Each location in its unique situation, however, has its unique problems. A workable solution for the Choctaws may not be workable for another location. Therefore, the above observations and recommendations from the Choctaw reservation should be examined with care. In addition, a careful study of the local tribal situation and the local IHS operations should be conducted before any decision is made. Resources for limited study and planning for 638 contracting are still available from the IHS. The opportunity for contracting and the potential of a 638 contract are much greater today for tribal contractors since many obstacles have been resolved during the past few years. Contracting under 638 is now fairly simple and should not be a decade-long process; and, before making the contracting decision, perhaps, the most important question a tribe has to ask itself is: "Are we ready to make commitment to the quality of care?"

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ABBREVIATIONS

638 or PL 93-638	Public Law 93-638, The Indian Self-Determination and Education Assistance Act of 1975.
BIA	Bureau of Indian Affairs
CAA	Choctaw Community Action Agency
CHC	Choctaw Health Center
CHD	Choctaw Health Department
CHR	Community Health Representative
CMC or CHS	Contract Medical Care Contract Health Care Contract Health Services
DHEW	Department of Health, Education, and Welfare
DIH	Division of Indian Health
EMT	Emergency Medical Technician
IHS	Indian Health Service
IPA	Intergovernmental Personnel Act
ISDM	Indian Self-Determination Memorandum
JCAH	Joint Commission on Accreditation of Hospitals
LPN	Licensed Practical Nurse
MBCI	Mississippi Band of Choctaw Indians
NHSC	National Health Service Corps
PHS or USPHS	United States Public Health Service
RN	Registered Nurse
USET	United South and Eastern Tribes (formerly United Southeastern Tribes)

EXHIBIT I

MISSISSIPPI BAND OF CHOCTAW INDIANS

TRIBAL COUNCIL MEMBERS, JULY 71-73

Phillip Martin	Chairman	Pearl River
Bobby Thompson	Vice Chairman	Bogue Chitto
Frank Steve	Secretary-Treasurer	Conehatta
Ralph Allen		Tucker
Roger Anderson		Conehatta
Tom Ben		Standing Pine
Albert Farve		Tucker
Dolphus Henry		Bogue Chitto
Joe Isaac		Pearl River
Odie Jim		Bogue Chitto
Bilbo John		Red Water
Murphy Solomon		Conehatta
Riley Thomas		Bogue Homa
Kirby Willis		Red Water
Marlin York		Pearl River
Hester York		Standing Pine

TRIBAL COUNCIL MEMBERS, 1973-75:

Phillip Martin	Tribal Chairman	Pearl River Community
Bobby Thompson	Vice-Chairman	Bogue Chitto Community
Frank Steve	Secretary-Treasurer	Conehatta Community
Allie Cooke		Tucker Community
Charlie Denson		Standing Pine Community
Maxine Dixon		Red Water Community
Albert Farve		Tucker Community
Clay Gibson		Pearl River Community
Grady Henry		Bogue Chitto Community
Jasper Henry		Bogue Chitto Community
Joe D. Isaac		Pearl River Community
Smith John		Red Water Community
Thomas Nickey		Conehatta Community
Jamison Solomon		Bogue Homa Community
Murphy Solomon		Conehatta Community
Agnes York		Standing Pine Community

TRIBAL COUNCIL MEMBERS, 1975-77:

Calvin J. Isaac	Tribal Chief	
Frank Steve	Vice Chief	Conehatta Community
Beasley Denson	Secretary-Treasurer	Standing Pine Community
Roger Bell		Pearl River Community
Allie Cooke		Tucker Community
Linwood Dixon		Standing Pine Community
Maxine Dixon		Red Water Community
Albert Farve		Tucker Community
Grady Henry		Bogue Chitto Community
Odie Jim		Bogue Chitto Community
Mack Jimmie		Pearl River Community
Thomas Nickey		Conehatta Community
Johnny Nickey		Bogue Homa Community
Jesse Thomas		Conehatta Community
Henderson Williams		Bogue Chitto Community
Kirby Willis		Red Water Community
William York		Pearl River Community

TRIBAL COUNCIL MEMBERS, 1977-79:

Calvin J. Issac	Tribal Chief	Conehatta Community
Frank Steve	Vice Chief	Pearl River Community
Phillip Martin	Secretary-Treasurer	Pearl River Community
William E. York, Jr.		Pearl River Community
William R. Bell		Red River Community
Maxine Dixon		Red River Community
Mattie K. Willis		Tucker Community
Albert Farve		Tucker Community
Rosalie Steve		Conehatta Community
Catherine Solomon		Conehatta Community
Carol Martin		Bogue Chitto Community
Hickman		Bogue Chitto Community
Houston Bull		Bogue Chitto Community
Zina Thompson		Bogue Homa Community
Johnny Nickey		Standing Pine Community
Clarence Comby		Standing Pine Community
Clifton Lewis		

TRIBAL COUNCIL MEMBERS, 1979-81:

Phillip Martin	Tribal Chief	Conehatta Community
Frank Steve	Vice-Chief	Pearl River Community
William E. York	Secretary-Treasurer (1980-1981)	
Hayward Bell		Bogue Chitto Community
Henry Bell, Jr.		Bogue Homa Community
Roger Bell		Pearl River Community
Houston Bull		Bogue Chitto Community
John Fred Denson	(resigned 1979)	Standing Pine Community
Maxine Dixon		Red Water Community
Albert Farve		Tucker Community
Clifton Hickman	Secretary-Treasurer (resigned in 1980)	Bogue Chitto Community
Mack Jimmie		Pearl River Community
Clifton Lewis		Standing Pine Community
Carol Martin		Conehatta Community
Catherine Solomon		Conehatta Community
Rosalie Steve		Tucker Community
Mattie K. Willis		Red Water Community
Clarence Comby	(replaced John Fred Denson)	Standing Pine Community

TRIBAL COUNCIL MEMBERS, 1981-83:

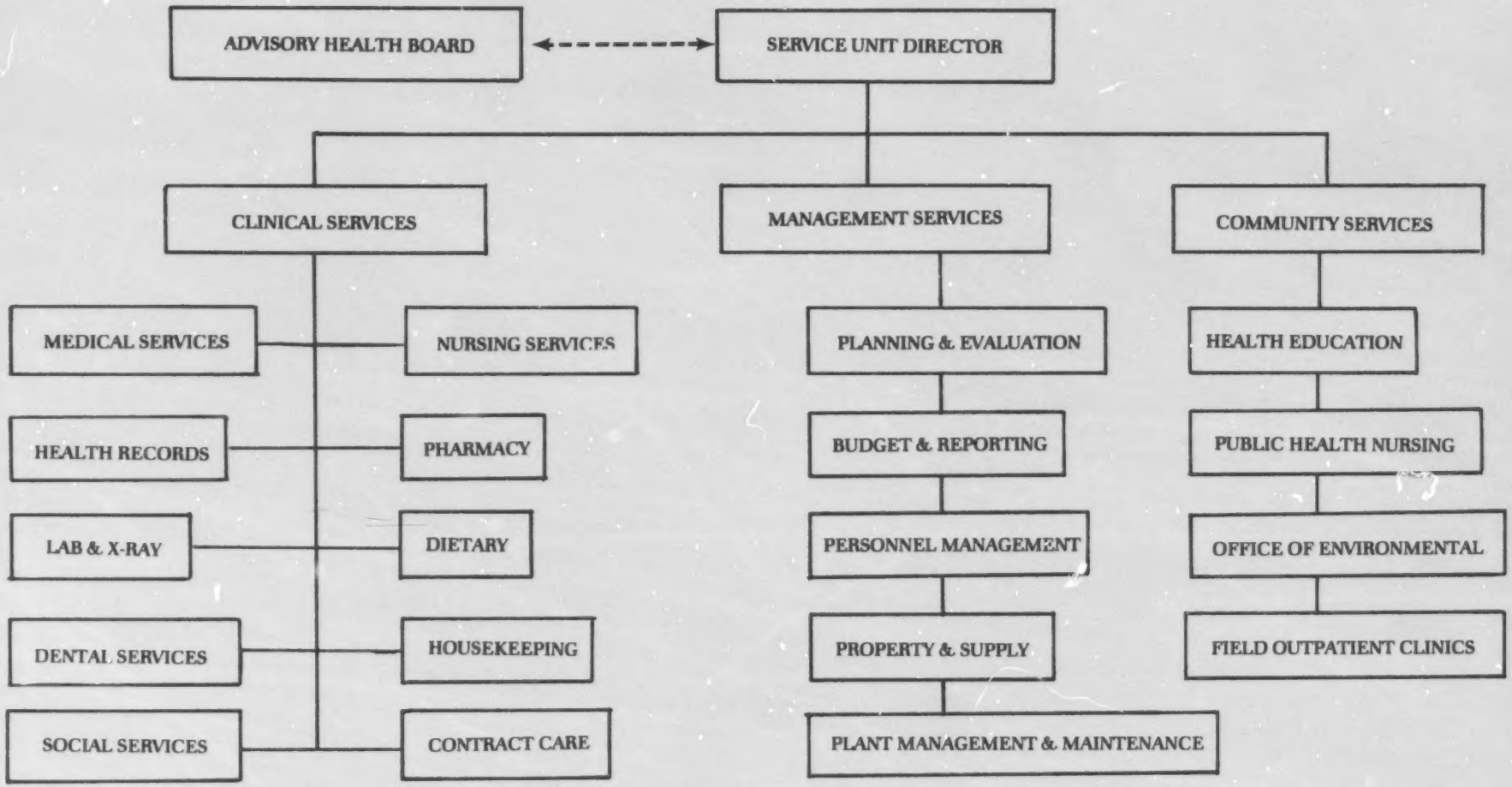
Phillip Martin	Tribal Chief	
Frank Steve	Vice-Chief	Conehatta Community
Beasley Denson	Secretary-Treasurer	Standing Pine Community
Roger Anderson		Conehatta Community
Hayward Bell	(resigned in 1982)	Bogue Chitto Community
Henry Bell, Jr.	(resigned in 1983)	Bogue Homa Community
Houston Bull		Bogue Chitto Community
Maxine Dixon		Red Water Community
Albert Farve		Tucker Community
Linda Farve		Pearl River Community
Doby Henry	(replaced Hayward Bell)	Bogue Chitto Community
Grady Henry		Tucker Community
Jasper Henry		Bogue Chitto Community
Luke Jimmie		Conehatta Community
Clifton Lewis	(resigned in 1982)	Standing Pine Community
Mattie K. Willis		Red Water Community
Stella Willis		Pearl River Community
William E. York		Pearl River Community
William Comby	(replaced Clifton Lewis)	Standing Pine Community
John Mingo	(replaced Henry Bell, Jr.)	Bogue Homa Community

TRIBAL COUNCIL MEMBERS, 1983-85:

Phillip Martin	Tribal Chief	
Frank Steve	Vice-Chief	Conehatta Community
Beasley Denson	Secretary-Treasurer	Standing Pine Community
Roger Anderson		Conehatta Community
Hayward Bell		Bogue Chitto Community
Houston Bull		Bogue Chitto Community
William Comby		Standing Pine Community
Maxine Dixon		Red Water Community
John Farmer		Tucker Community
Linda Farve		Pearl River Community
Grady Henry		Tucker Community
Jasper Henry		Bogue Chitto Community
Joe D. Issac		Pearl River Community
Luke Jimmie		Conehatta Community
John R. Mingo		Bogue Homa Community
Russell Willis		Red Water Community
Stella Willis		Pearl River Community

EXHIBIT II

* PROPOSED SERVICE UNIT ORGANIZATIONAL STRUCTURE



* Evaluation of the Choctaw Service Unit, 1972

EXHIBIT III

CHOCTAW HEALTH MANPOWER
Before and After 1976

	Before 1976	After 1976
Health Administrator (MPH)	0	1
Social Worker MSW	0	3
BSW	0	3
Medical Records Administrator (RRA)	0	1
Medical Records Technician (ART)	0	1
Registered Nurse (RN)	0	4
Graduate Nurse (Not Registered)	0	2
LPN	1	4
EMT	0	4
Nutrition (BS)	0	1
Total	1	24

EXHIBIT IV

THE CHOCTAW HEALTH DELIVERY SYSTEM TODAY

The Choctaw Health Delivery System includes the Tribal Council Health Committee and the Choctaw Health Department. The Choctaw Health Department is made up of four components: Community Health Service, Clinical Service, Support Service, and the Business Office. These four components are primarily located in the Choctaw Health Center. The Choctaw Health Center in Pearl River, completed in 1975, is a 58,800 square foot facility which includes a modern 35-bed general hospital, a three-chair dental suite, a Mental Health Center, a hemodialysis facility, and office space for administrative and support services. In addition to the Choctaw Health Center, there are three satellite Ambulatory Care Centers located in the Bogue Chitto, Conehatta, and Red Water communities. The Health Committee, an integral part of the Committee System, is housed at the old Tribal Office Building.

The organizational charts of the Choctaw Health Department can be found at the end of this document.

Tribal Council Health Committee

The five-member Health Committee has the primary responsibility of providing policy direction for the management and operation of the Choctaw Health Department. The Committee is also the direct link between the Choctaw people and professional and paraprofessional staff of the Choctaw Health Department.

The Chairperson of the Health Committee is also in charge of the office of Public Health Advisory. As such, he/she coordinates: public relations, patient advocacy activities for the Choctaw Health Delivery System and acts as liaison between the Tribe, the Indian Health Service, the Nashville Program Office, and the State on matters related to health.

Choctaw Health Department

The Choctaw Health Department is charged with the delivery of comprehensive health services to the Choctaw people with the goal of elevating their health status to the highest possible level. To accomplish this goal, the Choctaw Health Department has allocated its resources through contracts and grants to provide comprehensive health services. This health delivery system, subject to the control of the Health Committee, is designed to deliver high quality health services efficiently, effectively, and in a manner acceptable to the Choctaw people.

1. Office of the Director, Choctaw Health Department

The Director of the Choctaw Health Department, working under priorities established by the Tribal Council Health Committee, is responsible for the management of the Choctaw Health Department. Specific functions of the Director include the planning, direction, and evaluation of the health delivery system including the distribution, control and effective use of resources. The Director has final authority on Health Department plans, distribution of resources, and establishment of internal policies and procedures. He initiates program change and has final operational authority on major personnel actions. The Director is responsible for the coordination of the Choctaw Health Department with other tribal, local, state, and federal health programs in order to ensure that maximum health services are provided. In addition, he assures that grants and contracts are performed in accordance with funding program requirements. He also serves as the Health Officer, principal health advisor to the Choctaw Tribe in matters relating to health, and is directly responsible to the Chief. The Director provides supervision to the Director, Community Health Services; the Director, Clinical Service; the Director, Support Service; and the Manager, Business Office. He also maintains a close relationship with the Kidney Care Facility, which is directly operated by Kidney Care, Incorporated.

2. Community Health Service

The goal of the Community Health Service Program will not be to merely strive toward a Choctaw population whose sicknesses are to be treated, but to strive toward a population that never gets sick. A concerted effort will be made to assess and solve community health problems as seen and felt by community members; to assess school health education deficiencies in the schools and help school teachers to be more knowledgeable and comfortable in teaching health; to carry out basic screening programs to detect and treat health problems before they become serious; to provide preventive health services including eliminating and controlling the environmental factors; and to develop a sound management system to effectively coordinate community health services that are manned and carried out by capable personnel.

To effectively emphasize the prevention and health education approach in community health, the Health Education Consultant position within Community Health Service is upgraded to the Deputy Director, Health Education position with line of authority over other Community Health Service staff to facilitate the coordination and implementation of health education and prevention activities. The Deputy Director, Health Education supervises the Health Education Assistant and five Community Health Technicians whose activities are being directed toward health education, prevention, screening, case finding, etc., rather than transportation.

A sizeable portion of Community Health Service work is an extension of work begun and carried out in the hospital, the only difference being the level of care. In discharging these extension roles, the program acts as an intermediary between community people and hospital health care providers by facilitating communications between the clinical staff and the patient with a minimum of duplication, discomfort, and misunderstanding. To accomplish this, community health teams, consisting of Public Health Physician, Nurse Practitioner, Public Health Nurse, Health Educator, Community Health Technician, Audiometric Technician and others serve in each major community. These teams will provide a coordinated approach in the provision of screening preventive, and rehabilitative services in the community. These services will consist of the following major activities:

a) Disease prevention

b) Communicable disease control

c) Community health appraisal

d) Maternal and child health

e) Health education and patient education

f) School health services and school health education

g) Home health care

h) Counseling and referral.

In summary, the Community Health Service component of the Choctaw Health Department will assume major responsibilities in the fields of early screening, detection, health education, prevention, and follow-up with some primary health care services at three field clinics outside the Choctaw Health Center. The program will ensure that all outreach personnel will be directly involved in the health care system and that there will be planned interplay of the various health services which comprise comprehensive health care. With the exception of one Community Health Technician who operates independently in Bogue Homa, Mississippi, the major program components of the Community Health Service are located at the Choctaw Health Center and the Bogue Chitto, Conehatta, and Red Water clinics, and their activities include:

2.1) Field Clinics and Public Health Nursing.

The Community Health Service provides health services at various levels for the

Choctaw population. Primary care, immunization, preventive education, and follow-up services by the Public Health Physician, Family Nurse Practitioner, Public Health Nurse, and Community health Technicians are provided in communities, schools, home and field clinics. The field clinics program will be technically coordinated by the Public Health Physician who will coordinate community primary care activities. In conjunction with the Family Nurse Practitioner, he monitors community nursing standards in school, home, community, and field clinic settings to ensure program continuity and an orderly flow of communications between the field clinics and the Choctaw Health Center, as well as providing limited direct patient care. The field clinic operations are organized around one Public Health Physician, one Family Nurse Practitioner, two Clinic Coordinators, two Community Health Technicians, and one Field Records Clerk. Other tribal outreach workers, working from time to time in the communities, also work closely with the Public Health Physician and the Nurse Practitioner. The Nurse Practitioner operates under standing orders from the Public Health Physician and the hospital Medical Staff. The Public Health Physician and the Nurse Practitioner provide technical consultation to other personnel who are working in communities where field clinics are located. The Public Health Nursing services in the Pearl River Community are provided by a Public Health Nurse, supervised by the Director of the Community Health Service. These services include screening, disease prevention, and follow-up activities. All primary care services in this community are provided in the Outpatient Department at the Choctaw Health Center in Pearl River. The Public Health Nurse works closely with other outreach personnel assigned to this community. The Otitis Media Program is under the direction and supervision of the Director, Community Health Service. Technical consultation is available from the Public Health Nurse, Public Health Physician, the Medical Staff, and the Meridian Speech and Hearing Center. The goal of the Otitis Media Program is to provide screening services to detect hearing deficiencies within the population. The primary target group is all school and preschool age children. The secondary target group is the adult population.

2.2) Health Education.

Under administrative and technical supervision from the Director of the Community Health Service, the Deputy Director of Health Education is assisted by a Choctaw Health Education Assistant. He also supervises and coordinates activities of five Community Health Technicians who work in different communities. Funding for this program is not currently available from the IHS. However, the Tribe recognizes the importance of the program and is trying to revitalize it. The Health Education Program for the Choctaw Health Department is involved in three major areas of concentration. One area is to develop and implement a comprehensive bilingual patient education program for the hospital and field clinics with plans to include follow-up on the education component when the patient returns home. The patient education program includes inservice training for the staff on patient education, special programs, and development of educational materials including audiovisual materials. The health education activities are designed to improve communications between the staff and Choctaw people. Emphasis is placed on understanding of condition, treatment, maintenance, and prevention. In all possible areas, the family will be involved in the patient's education process. The second area of concentration is in school health education. The Health Education Program works with school staff to determine the school health education needs and the means to meet these needs. The Health Education Program is involved in providing inservice training for teachers in health, resource assistance to teachers, and health curriculum intervention. The Health Education Program works closely with the School Health Nursing Program in assisting the School Health Nurse in determining and meeting the identified health education needs of the students. The third area is to provide the Health Department staff with support services and advice in identifying and strengthening the education component of their work and assisting all departments in developing a program of inservice training and education. The Deputy Director

works closely with key staff and programs to accomplish this task. The Health Education Program also provides training, supervision, and preceptorship to health education assistants and trainees in pursuing a career in the field of health education. Another important aspect of health education is the training of Choctaw health professionals. As part of the long range strategy of Choctaw Self-Determination, the Tribe has emphasized the need to fill as many professional positions as possible with Tribal members. The Deputy Director has the responsibility for recruiting potential students from high schools and universities for entry into health fields. On an ongoing basis, the Deputy Director monitors their academic progress through periodic visits to and/or reports from their schools. Ultimately, the Deputy Director helps facilitate their placement within the Choctaw Health Department.

2.3) Eyeglass Program.

The Optometrist, on a part-time basis, provides vision examination, diagnosis, and optometric treatment of any vision anomalies referred to him by other professional staff. Services include duplication of patient prescriptions from glasses that have been worn by the patient, prescription verification, dispensing, and frame adjustments. This program is partially supported by the New Eyes for the Needy, Inc. The Optometrist is under the direct supervision of the Director, Community Health Service.

2.4) WIC Program.

The Director of Community Health Service oversees the operation of the WIC Program through the WIC Director. The program is funded by the USDA and provides supplemental food to pregnant women, breastfeeding women, infants, and children under five years of age. Nutrition education is a major component of this program.

2.5) Transportation.

Transportation poses a major barrier to Choctaw people seeking health care. Almost one-third of the Choctaw households have no family-owned means of transportation. The combination of the scattered communities and the overall lack of family vehicles makes access to health care services much more difficult for Choctaw people. In order to provide adequate transportation services to Indians in the communities, this program component is staffed with one Coordinator and three Drivers. They coordinate their activities with the Community Health Technicians and other outreach programs. Along with the Nursing Department, which provides Emergency Medical Technician services, the Transportation Program provides ambulance service to the hospital. The service is available 24 hours a day to the Choctaw population for emergency situations.

3. Support Service

The Support Service is responsible for providing administrative and technical support services to the Health Department. These functions include the responsibility for reviewing and analyzing modifications of existing or new policy or procedure releases relative to the general administration of contracts and grants and management of the Choctaw Health Department. These releases cover such activities as budget preparation, utilization of funds, modes of collection, personnel management, procurement services, property management, space utilization, security, third party liability reports, maintenance of commitment registers, maintenance and repair of facility and equipment, and many other facets of contemporary administration and management. This division has the responsibility for making certain that all applicable memoranda, personnel records, guides and instructions are maintaned in an up-to-date manner; it also advises the Director of the Choctaw Health Department on problems arising within the facility and recommends appropriate remedial action based on review of the problem. In a similar manner, this division renders staff assistance to professional personnel of the facility as necessary.

The Director, Support Service, under the direction of the Director, Choctaw Health Department and with the assistance of the Public Health Sanitarian and the Construction Inspector, has the basic responsibility of planning, budgeting, implementing, maintaining, managing, and appraising the sanitation facility construction and utility program on the Choctaw Reservation. Technical assistance is available from the USET-IHS Environmental and Sanitary Engineering Programs and/or outside consultants. In order to provide this service, he works closely with the Choctaw Utility Commission. Utility services provided include the following:

1) Approval of engineering designs, construction plans, specifications, engineering studies, and completed work for conformance to accepted engineering, public health, and administrative practices and policies.

2) Assistance in the construction of individual and community water distribution systems to provide a safe, potable water to the Choctaw consumer.

3) Assistance in the construction of individual and community waste disposal systems to insure removal of water-borne waste products.

4) Maintenance of existing community water supply and waste disposal systems through technical and manpower support to the Choctaw Utility Commission.

5) Technical assistance to the Choctaw Utility Commission, and advice and consultative services to other tribal and governmental organizations in matters relating to sanitary engineering.

6) Collection and disposal of solid waste generated by homes and institutions through a subcontract with the Choctaw Utility Commission.

7) Repair service for house fixtures and fixture plumbing through an agreement with the Choctaw Utility Commission.

Utility services construction is funded through a program of federal grants. The Choctaw Utility Commission is operated with income revenue generated from the sale of water, solid waste collection, and other services as outlined above.

The Director, Support Service directly supervises the Facility Manager, the Public Health Sanitarian, the Personnel Clerk, Supply Clerk, and the Purchasing Clerk.

3.1) Facility Operation.

The Facility Operation Branch, under the direction of the Facility Manager, has the prime responsibility for the repair, maintenance, alterations, improvements, and plant operation for all buildings, structures, utilities, and related facilities consisting of the Choctaw Health Center, field clinics, quarters, and other related structures. The Branch is also responsible for the operation, maintenance, and repair of all medical equipment within these facilities. It directly maintains a hospital and clinic housekeeping and janitorial program to insure a clean environment in all health facilities. It is also responsible for a comprehensive security program for patients and staff through direct personnel or contractual arrangements. The Facility Manager supervises one Assistant Biomedical Technician, one Air Conditioning/Heating/Refrigeration Mechanic, one Electrician, one Maintenance Work Leader/Plumber, one General Maintenanceman, the Executive Housekeeper, and two Telephone Operator/Security Guards.

3.2) Environmental Services

The basic function of the Environmental Services is the prevention of diseases by eliminating or controlling the environmental factors which form links in the chain of transmission. In order to meet this goal, emphasis is placed on the following objectives:

a) Comprehensive survey and sampling of existing water supply and distribution systems to insure that a safe and potable product is delivered to the consumer.

b) Comprehensive survey and sampling of existing waste disposal systems to insure that wastes are being treated or disposed of properly and do not represent a public health hazard.

c) Comprehensive surveys of Public Health Service, Bureau of Indian Affairs, and Tribal institutions to insure a safe and healthy environment.

e) In cooperation with the Mississippi State Board of Health, development a vector control, rabies control, and accident prevention program for the Reservation and adjacent areas.

The Public Health Sanitarian supervises the Sanitarian Technician and the Construction Inspector.

3.3) Personnel.

The Personnel Clerk has the responsibility for personnel, budget and finance relevant to the Choctaw Health Department personnel. The Personnel Clerk assures that the time and attendance reports, overtime and/or compensatory time justification, travel vouchers, and necessary reports are accurately and efficiently prepared in accordance with legal, regulatory and procedural controls. He provides assistance in assuring that all job descriptions are prepared accurately and that standards of performance have been developed. He makes arrangements for orientation of new employees and provides technical assistance to professional personnel in making personnel decisions.

3.4) Information/Reception.

Under the supervision of the Director, Support Service, the Information/Receptionists have the responsibility of greeting patients and the general public and assuring that visitors receive the correct information, instructions, or directions. They also staff the switchboard and route communications as required.

3.5) Property and Supply.

The Property and Supply Section is responsible for the procurement of all items of equipment, supplies, and services not only from mandatory sources, but also through open market purchase. It is responsible for maintaining an adequate inventory of supplies. The Supply Technician has responsibility as Custodial Officer for all equipment and maintains a complete and current catalog of sources for supplies and equipment.

4. Clinical Service

The Director, Clinical Service is the administrator of the hospital operations. The Director, under the direction and supervision of the Director, Choctaw Health Department, is involved in a wide variety of activities including: development of hospital evaluation mechanisms, implementation of standards for hospital accreditation, development of hospital policies and procedures, and development and participation in hospital committees.

He provides supervision to the Medical, Dental, Nursing, Laboratory, X-ray, Medical Records, Pharmacy, Dietary, and Social Services Sections, and the Community Mental Health Center.

4.1) Medical Staff

The Medical Director, who shall be a medical doctor and shall represent the Medical Staff on the Governing Body, is responsible for all day-to-day medical administration, including the efficient delivery of health care. In addition to maintaining quality and continuity of patient care

and supervising activities necessary for accreditation by the Joint Commission on Accreditation of Hospitals, the Medical Director is the primary advisor in medical matters to the Director of the Choctaw Health Department, Director of clinical services, other Directors of Services, and other health professionals at the Choctaw Health Center and field clinics.

The medical staff is responsible for providing physician services on both an inpatient and outpatient basis to the Choctaw people. The medical staff, with six physicians, including the Medical Director and the Public Health Physician, provides technical consultation to Nurse Practitioners, the Public Health Nurse, and other professional and paraprofessional health staff in terms of standing orders and standards of care. It also provides medical services and coverage to the field clinics directly or through the Public Health Physician assigned to Community Health Service. A physician may serve as a preceptor for Nurse Practitioner students. The medical staff, through the Medical Director, maintains responsibility for the performance of all medical students, interns, or residents who, as part of their practicum, rotate through the facility.

4.2) Dental

The Dental Section provides dental health services to the Choctaw people and develops, coordinates, implements, and evaluates the dental program for both direct and contract services. The Dental Section is responsible for the authorization of funding under the contract dental care program. It monitors the Community Preventive Dentistry Program through the Dental Hygienist. The Dental Assistants aide the Dental Officers in maintaining the effectiveness of the program as outlined in the IHS Dental Resources Criteria and Standards and in accordance with priorities for operation established by the Tribal Council Health Committee. The Dental Section has a staff of two Dental Officers, one Dental Hygienist, and four Dental Assistants; three operatories at the Pearl River Clinic, two operatories at Bogue Chitto and two at Conehatta. Plans are being made to set up one additional operatory in the Tucker Community with one additional Dentist and one Dental Assistant.

4.3) Nursing Section

The Nursing Section provides professional nursing services to inpatients and outpatients at the Choctaw Health Center, both as primary providers of care and under orders of the medical staff. It also provides Emergency Medical Technicians for ambulance service. It operates the Ambulance Service with the assistance of the Transportation Department of Community Health Service. The Nursing Section is headed by a Director of Nursing, assisted by an Assistant Director of Nursing, four Nurse Supervisors, thirteen Registered Nurses, two Licensed Practical Nurses, three Emergency Medical Technicians, eleven Nursing Assistants and one Secretary.

4.4) Laboratory and X-Ray Section

The Laboratory and X-Ray Section operates as a supportive unit to the medical staff by providing laboratory and x-ray services to assist the medical staff in reaching a diagnosis and in monitoring health conditions. The Laboratory Section provides consultative services to the Nurse Practitioners in the field clinics and helps establish routine quality control procedures for field clinic laboratory services. A Medical Technician is in charge of laboratory operations. Under his supervision are two Medical Technologists, a Radiology Technologist, one Laboratory Technician and a Secretary.

4.5) Nutrition-Dietetic Service.

The Nutrition Dietetic Service is responsible for providing therapeutic and normal diets to the inpatients at the Choctaw hospital, and for providing nutritional and dietary counseling to inpatients, outpatients, staff, other institutions, and the community. The Dietary Department is responsible for managing the subsistence budget so that inpatient meals are prepared attractively, are acceptable to the Choctaw people, and meet the therapeutic regimen prescribed by the physician. It also provides meals to the staff at cost. The Nutrition-Dietetics Section

provides counseling on an individual and group basis on dietary control of disease conditions and provides consultant services on diet therapy to health professionals. The section also conducts demonstrations using food models and audio/visual techniques and attempts to assure the overall nutritional well-being of the Choctaw people. It is staffed with a Registered Dietician who supervises one Cook Foreman, three Cooks, three Food Service Workers, and provides administrative and technical support to the WIC Program.

4.6) Pharmacy Section

The Pharmacy Section, at the direction of the medical staff, provides drugs of accepted and recognized quality to both inpatients and outpatients with the provision of consultant and counseling services to ensure that these drugs are utilized correctly, both in the facility and in the home. The Pharmacy Section establishes procedures regarding evaluation, selection, control and utilization of drugs. In this connection, a hospital formulary is established and all adverse drug reactions are investigated. The Pharmacy Section maintains a unit dose system and an IV Additive Program within the facility and provides consultation to physicians and nurse practitioners on the selection and utilization of drugs. Dispensing and counseling services are provided to individual outpatients in response to the physician's written prescriptions. The Pharmacy Section provides direct services through an over-the-counter program and the follow up of selected chronic disease patients in accordance with standards of care developed by the medical staff. The section is staffed with three Pharmacists and one Pharmacy Assistant.

4.7) Medical Records and Admission Section

The Medical Records and Admission Section is responsible for the maintenance of individual patients' medical records, admission of patients, and screening of patients who are eligible for alternative resources such as Medicare/Medicaid, Veterans Benefits, private health insurance, etc. The Medical Records Section is responsible for assuring that the confidentiality of records is maintained and also carries out the provisions of the Privacy Act with regard to medical records. This section provides consultation to field clinics and assures an orderly flow of information from the hospital to the field clinics on a need-to-know basis. They provide assistance to the medical staff in performing internal audits to assure the quality of patient care and appropriate utilization of services. Additionally, the Medical Records Section provides statistics which may be used for epidemiological and/or management purposes. The Medical Records Section is the focal point for the appointment system, for pulling and filing routine records within the Outpatient Department, and for preparing the medical records for a hospital admission.

4.8) Physical Therapy Section

This newly proposed section is under the direction of a Physical Therapist who reports to the Director, Clinical Service. Staffing also consists of one full-time Physical Therapy Aide who is trained on-the-job.

The program provides treatment and/or prevention of disability, injury, and/or disease by the performance and interpretation of tests and measurements of physiological functions as an aid to:

1) evaluation of disability, and

2) the physical treatment.

This Section is on the priority unmet list of the Tribal Specific Health Plan. It is a service of great importance in an institution not having full time orthopedic coverage such as the Choctaw Health Center. It provides rehabilitative care to chronic as well as acute patients such as diabetic, cardiac, arthritic, and industrial patients. Funding for this section is not currently available from the IHS or any other resources.

4.9) Social Service

The Medical Social Worker provides medical social services to Choctaw individuals and families to resolve or alleviate social problems related to health. Such services may be different or indirectly rendered through referral to other members of the health team of appropriate agency.

4.10) Community Mental Health Center

The Director, Community Mental Health Center is under the direct supervision of the Director, Clinical Service. He provides direction and supervision to the counseling staff and the administraive staff. He also provides psychological evaluation and treatment to the patients and inservice training to the counseling staff. The counseling staff works closely with Choctaw clients who are afflicted with mental health/alcoholism disorders and substance abuse. The Community Mental Health Center provides a wide range of services directly through its staff or indirectly through coordination with other Choctaw Health Department staff, other mental health hospitals or centers and other treatment and rehabilitation resources. These services include counseling,, prevention eduction, information, referral for health care, employment, housing, social assistance, transportation, court appearance with client, release contract, follow up, etc.

5. Business Office

Under the direct supervision of the Director, Choctaw Health Department, the Business Office is responsible for the operation of the Contract Health Care Program and the Third Party Reimbursement Program.

The Business Office Manager supervises the Contract Health Care Clerk and the Billing Clerk. This office maintains close liaison with the Clinical Director, medical, and professional staff so that needed contract health care is provided. It negotiates contracts and maintains a good working relationship with contract hospitals and/or physicians. It provides coordination for the identification of third party resources to assure that all alternate resources are exhausted before contract health care funds are utilized. Additionally, it is also responible for the day-to-day billing activities.

6. Kidney Care Facility

The Kidney Care facility is a cooperative arrangement between the Mississippi Band of Choctaw Indians and Kidney Care, Incorporated to provide hemodialysis treatments to Indian patients who are eligible for Indian Health Service services. Kidney Care, Incorporated is a non-profit organization providing treatment, education, and research for kidney disease. Its home office is in Jackson, Mississippi.

The incidence of Choctaw Indians with chronic kidney disease is approximately two or three times the national average. Before the establishment of the Kidney Care facility at the Choctaw Health Center, the kidney patients had to travel three times a week to Meridian to receive the treatments which are paid for by Medicare, Medicaid, insurance, and IHS Contract Health Care Program funds.

In 1983, the Choctaw Health Department utilized space provided by the Indian Health Service under a revocable license as an in-kind contribution to establish the Kidney Care facility operated by Kidney Care, Incorporated.

Kidney Care, Incorporated is responsible for the management, technical supervision, and quality assurance of this facility. In addition to the physical facility, the Choctaw Health Department also provides the following supportive services to the Kidney Care Facility at the Choctaw Health Center: telephone, utilities, housekeeping, groundskeeping and maintenance, emergency room back-up and ambulance service, and laboratory support.

Kidney Care, Incorporated is reimbursed by Medicare, Medicaid, and private insurance for services provided to Indian patients. The Choctaw Health Department no longer has to utilize Contract Health Care funds to pay the balance after Medicare and insurance reimbursements or for services provided to patients who do not have any alternate resource.

This five-unit Kidney Care facility also provides services to non-Indian patients and has greatly improved the well-being of the kidney patients. It is making funds available for other needed contract health services.

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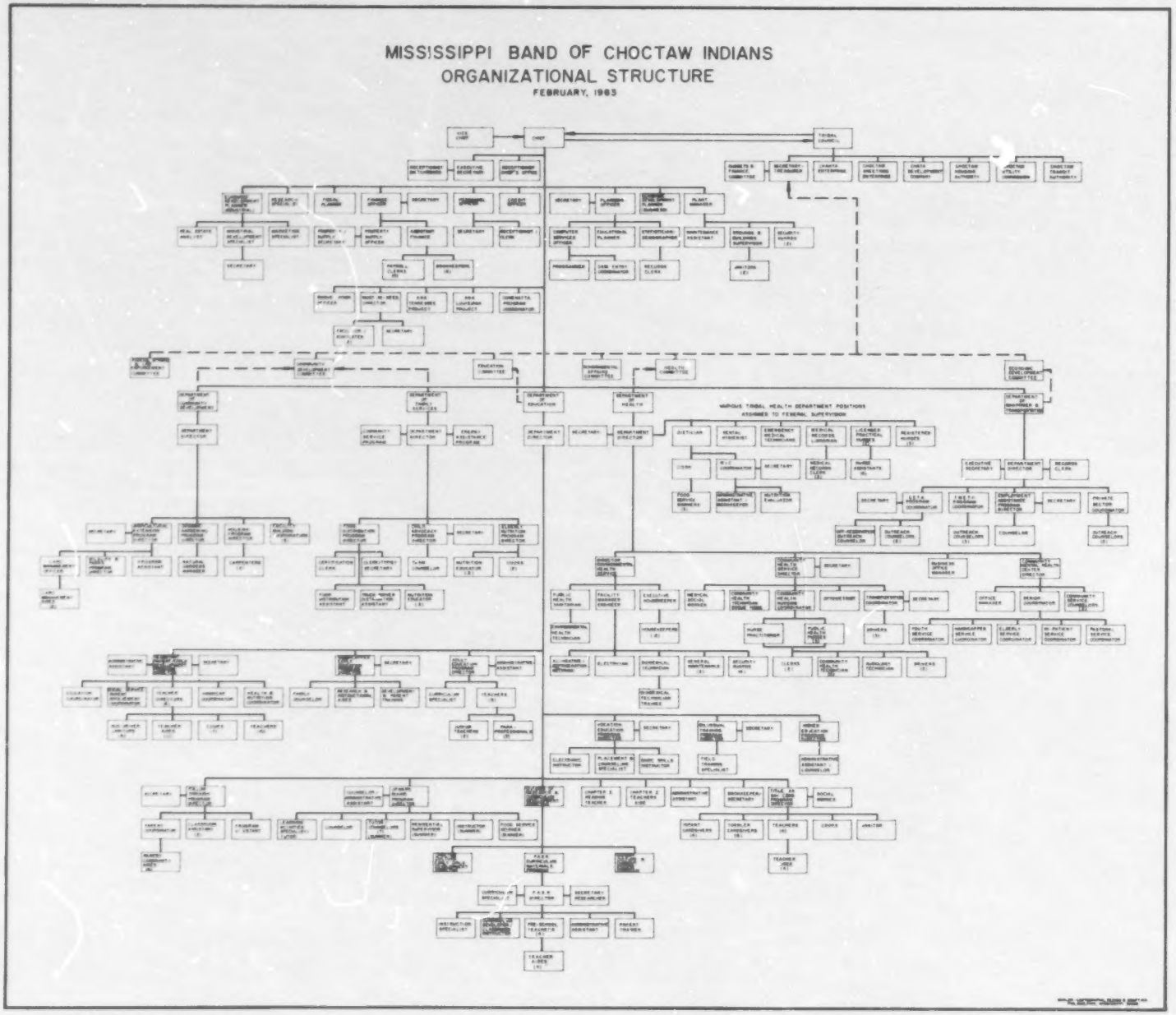
MISSISSIPPI BAND OF CHOCTAW INDIANS
ORGANIZATIONAL STRUCTURE
FEBRUARY, 1983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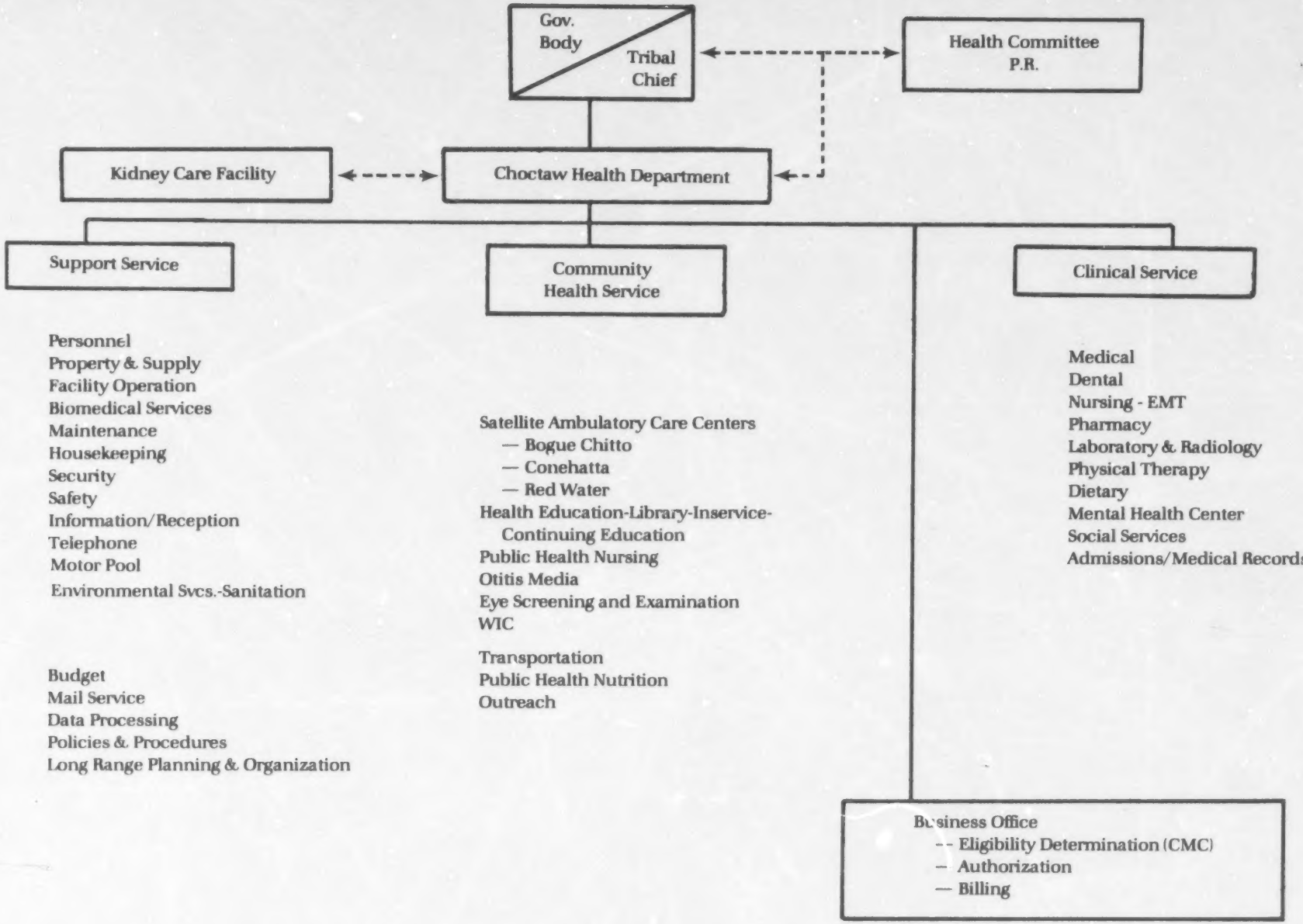
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Tribal Chief
Health Committee P.R.
Kidney Care Facility
Choctaw Health Department
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Community Health Service
Clinical Service
Personnel
Property & Supply
Facility Operation
Biomedical Services
Maintenance
Housekeeping
Security
Safety
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Telephone
Motor Pool
Environmental Svcs.-Sanitation
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Policies & Procedures
Long Range Planning & Organization
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— Conehatta
— Red Water
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Public Health Nursing
Otitis Media
Eye Screening and Examination
WIC
Transportation
Public Health Nutrition
Outreach
Medical
Dental
Nursing - EMT
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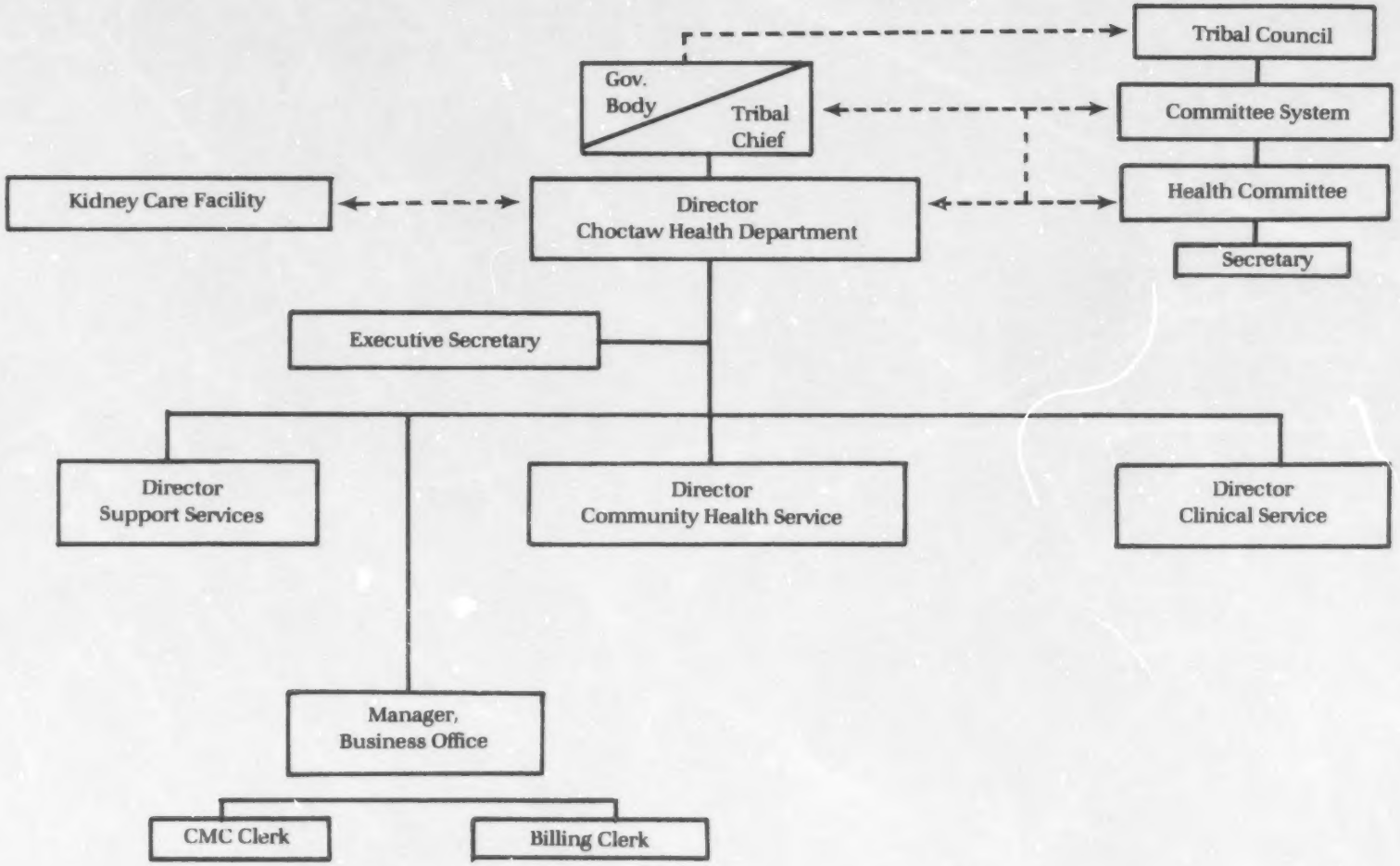
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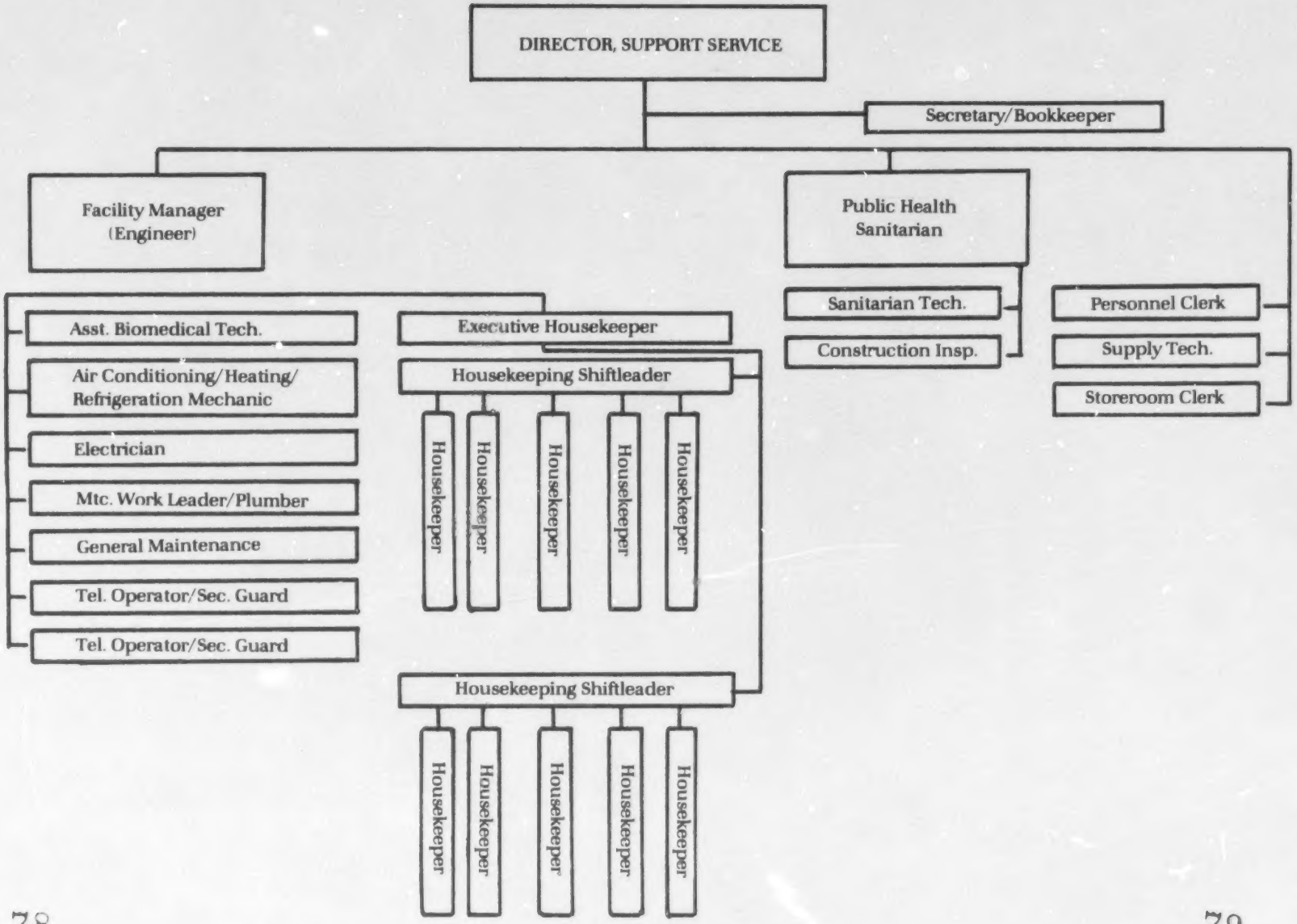
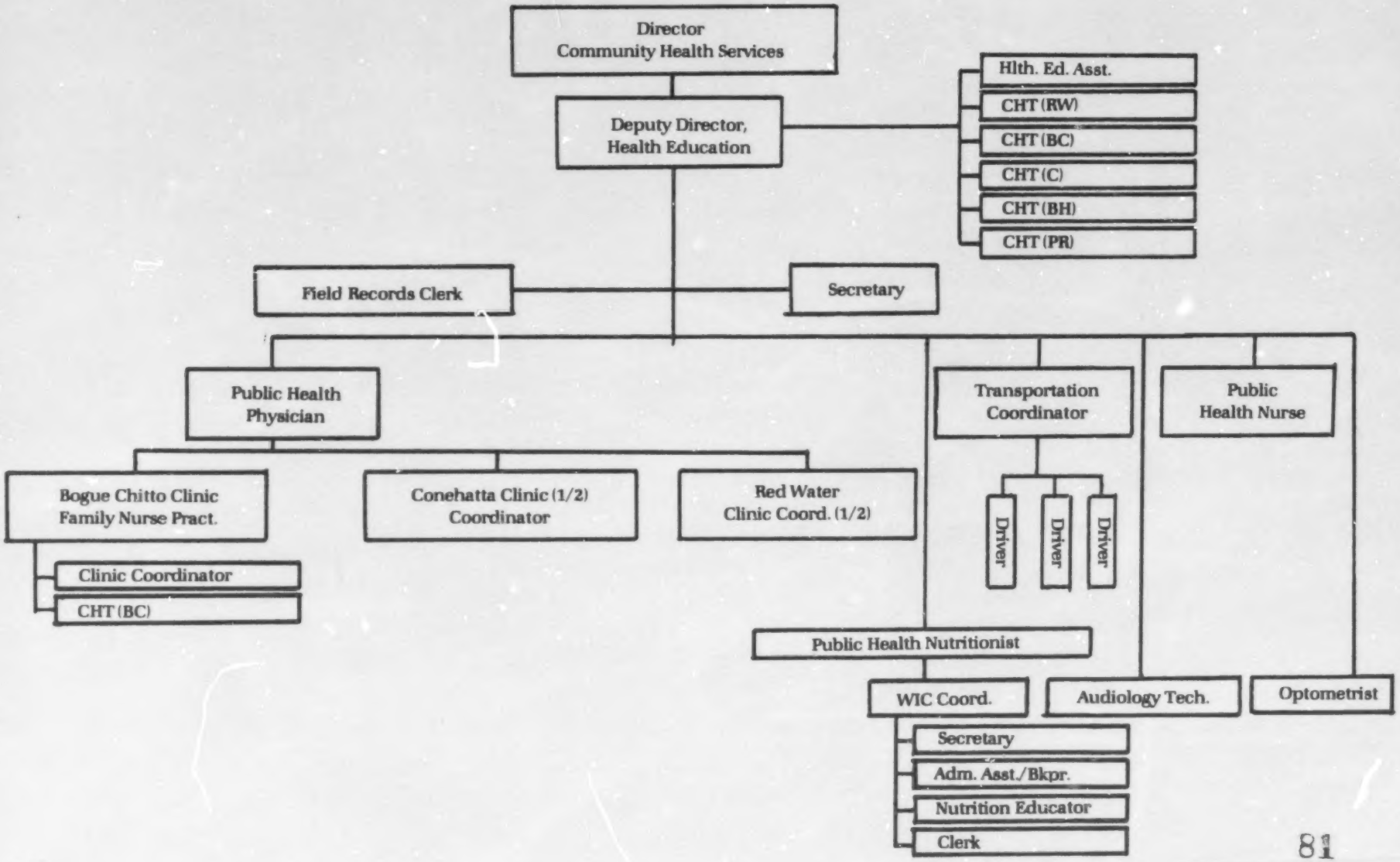
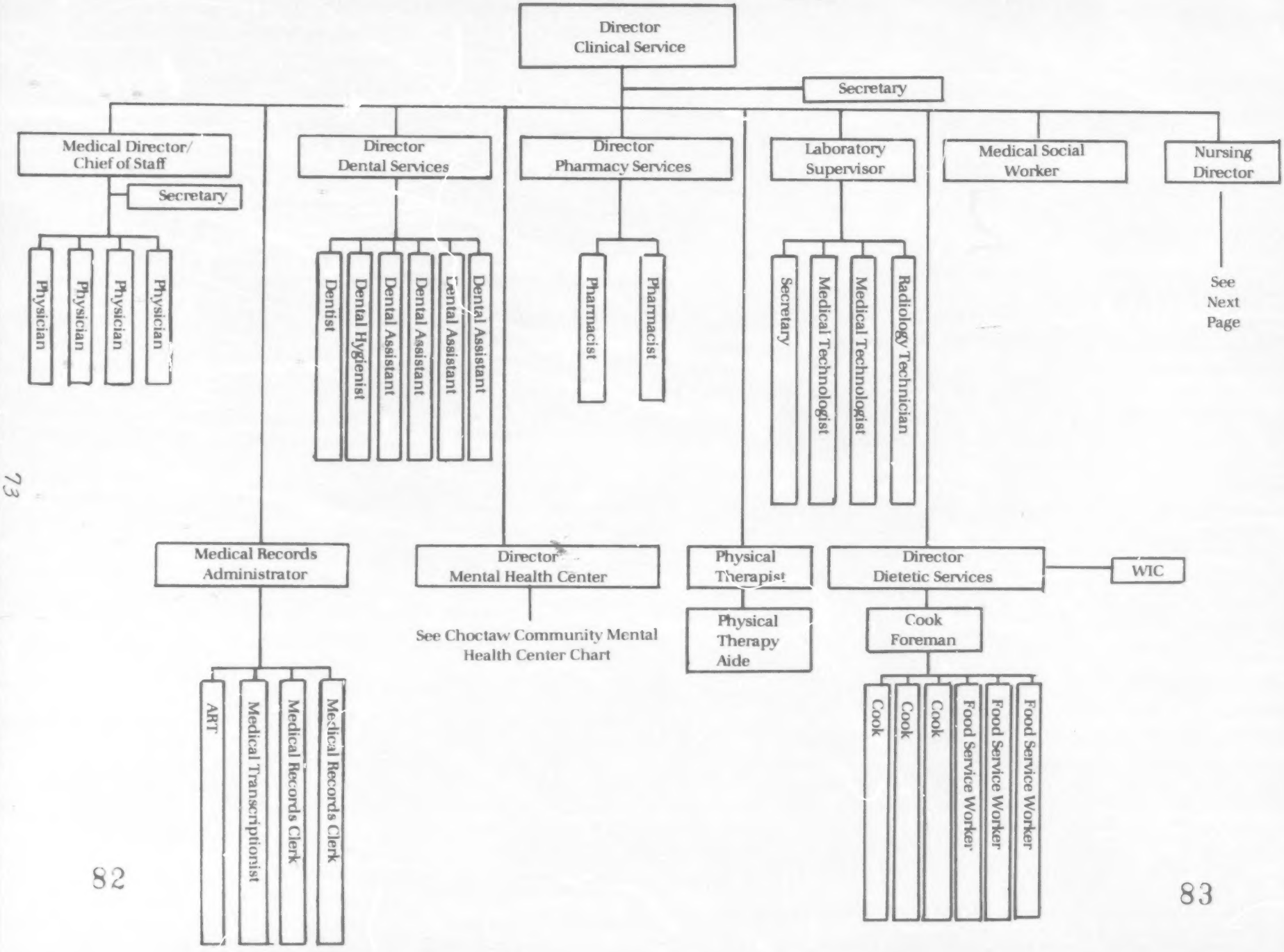
Gov. Body
Tribal Chief
Committee System
Kidney Care Facility
Director
Choctaw Health Department
Health Committee
Secretary
Executive Secretary
Director
Support Services
Director
Community Health Service
Director
Clinical Service
Manager,
Business Office
CMC Clerk
Billing Clerk

SUPPORT SERVICE




Director
Community Health Services
Deputy Director,
Health Education
Hlth. Ed. Asst.
CHT (RW)
CHT (BC)
CHT (C)
CHT (BH)
CHT (PR)
Field Records Clerk
Secretary
Public Health
Physician
Transportation
Coordinator
Public
Health Nurse
Bogue Chitto Clinic
Family Nurse Pract.
Conehatta Clinic (1/2)
Coordinator
Red Water
Clinic Coord. (1/2)
Driver
Driver
Driver
Clinic Coordinator
CHT (BC)
Public Health Nutritionist
WIC Coord.
Audiology Tech.
Optometrist
Secretary
Adm. Asst./Bkpr.
Nutrition Educator
Clerk


Director
Clinical Service
Secretary
Medical Director/
Chief of Staff
Secretary
Physician
Physician
Physician
Physician
Director
Dental Services
Dentist
Dental Hygienist
Dental Assistant
Dental Assistant
Dental Assistant
Dental Assistant
Director
Pharmacy Services
Pharmacist
Pharmacist
Laboratory
Supervisor
Secretary
Medical Technologist
Medical Technologist
Radiology Technician
Medical Social
Worker
Nursing
Director
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Medical Records
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Medical Transcriptionist
Medical Records Clerk
Medical Records Clerk
Director
Mental Health Center
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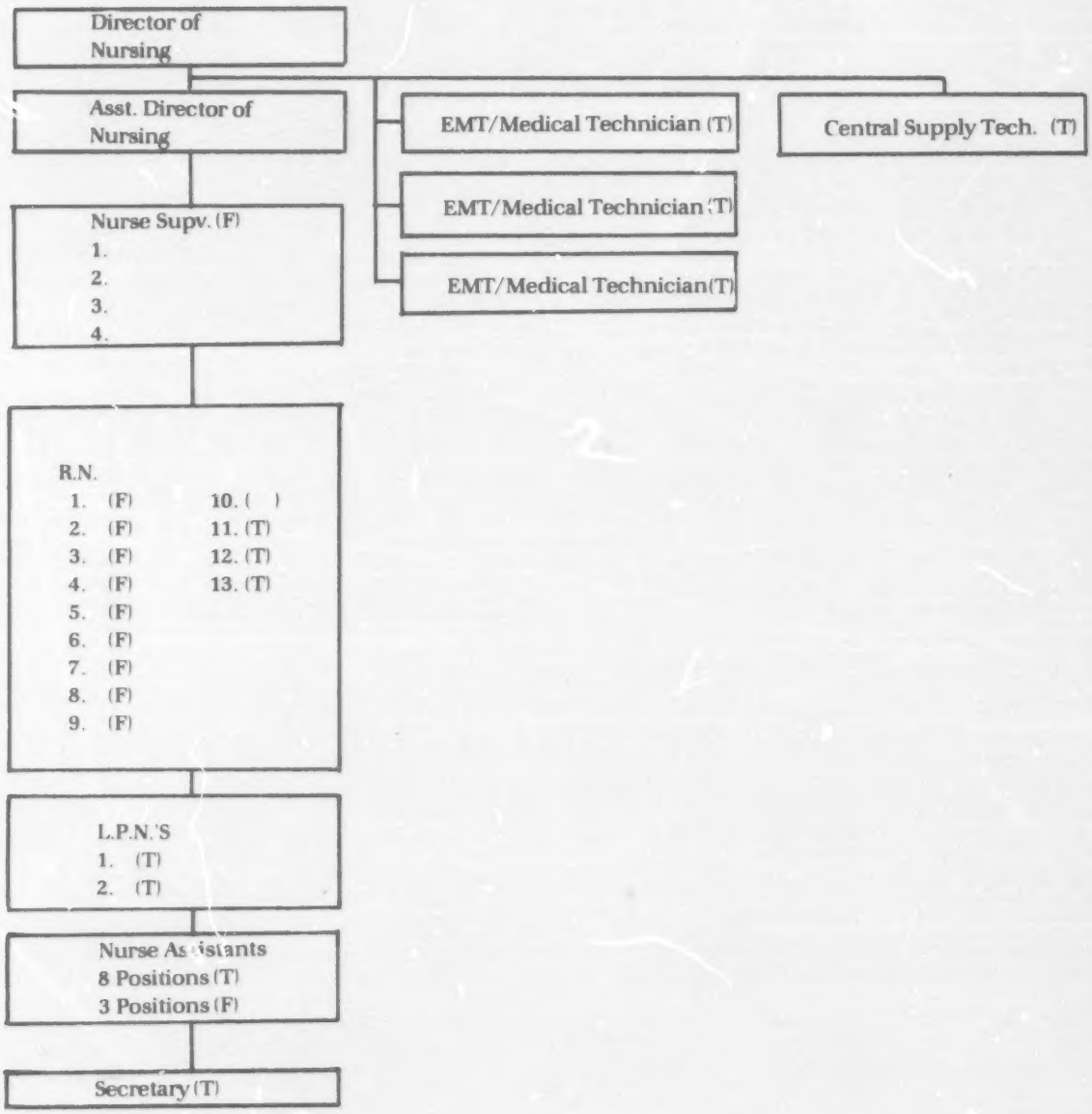
Health Center Chart
Physical
Therapist
Physical
Therapy
Aide
Director
Dietetic Services
WIC
Cook
Foreman
Cook
Cook
Cook
Food Service Worker
Food Service Worker
Food Service Worker

73

82

83

NURSING


Director of Nursing
Asst. Director of Nursing
EMT/Medical Technician (T)
EMT/Medical Technician (T)
EMT/Medical Technician (T)
Central Supply Tech. (T)
Nurse Supv. (F)
1.
2.
3.
4.
R.N.
1. (F)
2. (F)
3. (F)
4. (F)
5. (F)
6. (F)
7. (F)
8. (F)
9. (F)
10. ( )
11. (T)
12. (T)
13. (T)
L.P.N.'S
1. (T)
2. (T)
Nurse Assistants
8 Positions (T)
3 Positions (F)
Secretary (T)

CHOCTAW COMMUNITY MENTAL HEALTH CENTER

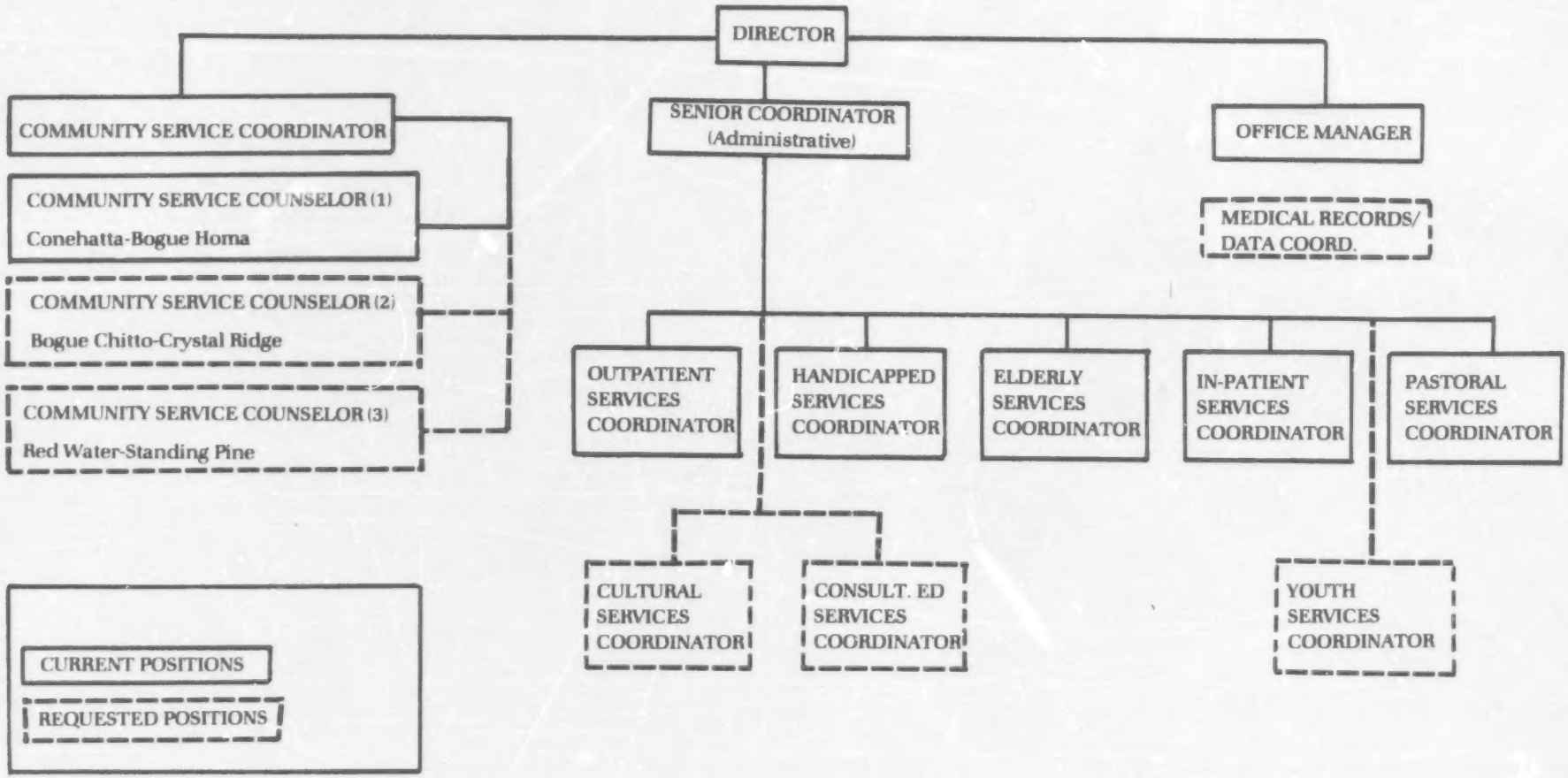


EXHIBIT V

MISSISSIPPI BAND OF CHOCTAW INDIANS
FUNDING FOR HEALTH SERVICES
BY FISCAL YEAR
(FY 71 - FY 75)

PROGRAMS	FUNDING AGENCY	FY 71	FY 72	FY 73	FY 74	FY 75	TOTAL
CHR	IHS	32,000	38,000	85,860	90,990	143,759	390,609
Health Education	IHS			15,750	33,750	22,000	71,500
Mental Health	IHS			21,947	58,992	43,896	124,835
Otitis Media	IHS				25,000	30,000	55,000
West Tennessee Indian Health Proj.	IHS					20,000	20,000
Community Health Coordinator						15,000	15,000
Alcoholism	NIAAA				33,540	61,600	95,140
Appalachian Regional Commission	State				40,672	40,672	81,344
National Health Service Corps Assignees	NHSC			60,000*	60,000*	60,000*	180,000
TOTAL		32,000	38,000	183,557	342,944	436,927	1,033,428

* Estimated amount for 3 professional assignees.

MISSISSIPPI BAND OF CHOCTAW INDIANS
FUNDING FOR HEALTH SERVICES
BY FISCAL YEAR
(FY 76 - FY 80)

PROGRAMS	FUNDING AGENCY	FY 76	FY 77	FY 78	FY 79	FY 80	TOTAL
Choctaw Health Department	IHS	435,842	1,147,351	1,163,312	1,288,296	2,028,336	6,073,137
Tribal Data System	IHS			238,825			238,825
Health Committee	IHS			83,645			83,645
Alcoholism	NIAAA	59,290	59,290	50,529	60,500 (1)		229,609
Appalachian Reg. Commission	State	40,672	40,687	40,514	39,445	41,578 (2)	202,896
WIC	USDA		257,000	218,700	249,461	347,316	1,072,477
Child Advocacy	HEW	174,649	159,091	193,931	(3)		527,671
Alcohol and Drug Abuse	State			23,076	24,172	24,172	71,420
NHSC	HEW	60,000*	60,000*	45,000*	45,000*	45,000*	255,000
TOTAL		770,453	1,723,419	2,057,532	1,706,874	2,446,402	8,754,680

(1) Transferred to IHS at the end of FY 79 and subsequently funded through Choctaw Health Department.
(2) Transferred to Choctaw Department of Human Services. Funding for this program stopped the same fiscal year.
(3) Transferred to Choctaw Department of Human Services. This program is being funded through different funding sources. (B)
* Estimated amount based on number of assignees and their disicpline.

MISSISSIPPI BAND OF CHOCTAW INDIANS
FUNDING FOR HEALTH SERVICES
BY FISCAL YEAR
(FY 81 - FY 84)

PROGRAMS	FUNDING AGENCY	FY 81	FY 82	FY 83	FY 84	TOTAL
Choctaw Health Dept.	IHS	2,659,308	3,132,017	3,153,441	3,841,892 (+1,119,343) (1)	13,906,001
WIC	USDA	461,545	324,599	334,565	315,378	1,436,087
Alcohol and Drug Ab.	State	24,172	26,217	26,217	26,217	102,823
Health Education Risk Reduction	State	66,350	65,144			131,494
NHSC	HEW	50,000*	75,000*	100,000*	100,000*	325,000
Hemodialysis Facility	Kidney Care, Inc.			30,000**	75,000**	105,000
Eyeglasses Program	New Eyes For the Needy	21,000**	5,000**	7,500**	7,500**	41,000
TOTAL		3,282,375	3,627,977	3,651.723	5,485,330	16,047,405

(1) Retained by IHS to pay federal employees who are assigned to the tribe.
* Estimated amount based on number of assignees and their professional discipline.
** Estimated amount.

Hospital Lobby, Choctaw Health Center

Submitted by the Mississippi Band of Choctaw Indians to the Nashville Program Office, Indian Health Service, May 1984, to fulfill the requirement for Documentation of Health Program Management under contract 285-81-0005. This document was prepared by Binh N. Nguyen, MPH. The opinions expressed herein do not necessarily reflect the position or policy of the Indian Health Service; and no official endorsement of that office should be inferred. This publication is paid for by the Mississippi Band of Choctaw Indians.

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An aerial view of the Choctaw Health Center, Pearl River community.

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